

Senate Select Committee on **MEDICAID REFORM**

Lisa Carlton, Chair Jeffrey Atwater, Vice Chair

This packet contains written comments from the public received during the Medicaid Reform meeting held in *Tampa* on February 11, 2005.

All comments submitted have been included in their entirety for consideration by members of the Senate Select Committee on Medicaid Reform and the House Select Committee on Medicaid Reform.

DIS-ABLED NEWS U.S.A. © 1975 FREE

Sunrise Mobile Park LOT 11C 18118 N. U.S. 41 LUTZ, FL 33549

howcanilive@mybluelight.com
Hillsborough county division
813/242-7680

OUR MOTTO: <u>THE SKIN OF WISDOM HAS NO COLOR</u>
WE OWN THE COPYRIGHTS FOR THE FRUIT, FLOWER AND
BIRD PLACED ON TOP OF THE FEDERAL WHEEL CHAIR
LOGO. AVOID ALL LEGAL ACTION. Please do not infringe without
written permission

This is the original Dis-Abled News U.S.A. that hand delivered one million FREE copies nationwide, to create the domestic action you see happening today in America. My ten-year distribution TOTAL cost? Is \$20,000? OF PERSONAL MONEY. MARCH 2005 ISSUE:

February 11,2005 MEDICARE FORUM @ THE SAM GIBBONS HALL ON THE USF CAMPUS

CONSTITUENTS NEED a 5 CENT <u>NATIONAL</u> COMMODITY SALES TAX TO SHORE UP SOCIAL SECURITY, AND PROGRAM FREE HEALTH CARE 4 ALL:

Studying the facts that Social Security is going bankrupt, I come to the conclusion that creating personal retirement accounts is not the way to keep the <u>FDR. SS RETIREMENT IDEA</u>, <u>ALIVE</u>. Yes we need to begin to debate how to increase cost of living benefits for the retired, the elderly and dis-abled or indigent constituent. In America we are free to create better mousetraps. Instead our leaders, Lawmakers, Bankers and all types of manufactured products are the culprits of the obsolete system that is bleeding American taxpayers to death.

The truth about Social Security is being exposed after seventy years of secured income for all of the retired elderly. President Roosevelt intended for Social Security to be a temporary crutch because during the depression his idea would begin to support the people at an age when they would not be hired anymore because they would be too old to work the hard hours of labor. Now President George W.. Bush saw the opportunity to step on the political third rail to cause a short on the train (Social Security) system, because it is his last term in office, But many of his political friends will also short circuit their voting powers if they agree to dissolve the best retirement system in the world.

In the early 1900s every bank in America gave five cents in interest per year, on each dollar placed in the bankers hands. The Banks through public education convinced students that putting money in the bank was a safe measure that could not be stolen by house thieves who knew that immigrants hid their money under the mattress so to speak. When the banks invested the Money we placed in their care, they more than doubled their future assets by buying up as much real estate as possible from year to year. Today the same Banks give us 2 cents on each dollar we save, each year. The system continues to fall backwards for the constituent investor.

Manufacturers gave workers less than seventy-five cents per hour for their labor almost up to 1950. The Union movement stepped in and forced labor increases that today demand a \$ 6.00 per hourly minimum wage. The teenager who graduates from high school starts earning \$ 200.00 per week and begins going on spending sprees and supporting bad habits.

Last but not least, lawmakers make criminal activity changes that entice vandalism, burglary and all sorts of crime to increase. This is a costly venture that the candidates we voters place in office to protect freedom have taken advantage of to release criminals in order to save the state budgets.

All the above mentioned is a true statement concerning the direction America is going. We are leaning towards a <u>trilateral dictatorship in American government bodies</u>. Since the Federal Congress of the Senate and the House of Representatives were formed and the presidents administration is the asking for approval of all lawmaking, our judicial system agrees most times for, the government body rather than for, the health and welfare of we the constituents who are the majority.

Every state in the union operates the same trilateral system. Today our government is in full control of all of the media. The media in general

depends on the millions of campaign dollars spent every year during elections. Automatic termination exists if a journalist speaks out against our government. We need to let our lawmakers know through e-mail and postal mail that reforms need to be adjusted to satisfy we the people. If our government can occupy and change another nations way of government, what will stop our government from dictating how we can live inside our own country. Our freedom. Yours and mine have reach the limits of the man made laws that are taking away our rights. And that includes the right to free speech. My own Catholic Church, Corpus Christi and the Mercantile Bank in Temple Terrace Florida have violated my freedom of this press. The Catholic Church has no right to invade my personal privacy, and neither the Mercantile Bank. For many it is not a big deal. But for me the advocate for freedom of speech it is. []

THE SOCIAL SECURITY & FREE HEALTH CARE COMMODITY SALES TAX ISSUE

President Bush says his administration will not raise taxes. The president is pushing out the Social Security retirement system. Be aware that should The personal retirement investment structure pass for approval for those under 55 years of age; Future lawmakers, including future presidents, will continue to eliminate the former President Roosevelt Social Security Program. Just like the banks and manufacturers did, Social Security will continue to be cut lower and lower. The youth of tomorrows retirement age will have less to continue living.

President Bush has an idea to create windfall profits through the stock market and insurance professional. To prove my point, save this article for the youth in your home to read when Social Security is discontinued in their retirements of life. Our government leaders finally woke up in full support of our troops. They have increased insurance death policies to the loved ones left behind. But to support the family that sacrifices a troop soldier to keep America free, there is no increase in soldiers pay.

For generations our Americans went to war to free dictatorship countries. We have lost millions of American soldiers and created disability for the troops who come home alive. We are not correctly assisting disabled Americans through the veteran hospital system or compensation for the loss of memory, arm or leg. In fact our disabled cannot get jobs from our own American industries.

WITH A 270 MILLION NATIONAL POPULATION, THE PRESIDENT WILL HAVE TO RAISE TAXES

Most importantly the government needs to eliminate the pork add on bills that are in the passing zone. A moratorium to continue paying to rebuild other countries America destroys needs to be set. America needs to rebuild its own deteriated cities in all states. We need to worry about all of our own domestic issues before breaking the taxed dollar back of our labor force.

By adding a five-cent (5 cent) commodity federal national sales tax, our constituents can afford to pay as we go to shore up the present Social Security System. All commodity sales tax that amount under the \$1,000. Figure of commodity sales per person, would go into a federal slush fund. Splitting two and a half cents to shore up the present Social Security System, and the other two and a half cents would create a free health care program nationwide. No co-payments for drugs or doctor visits or hospital stays. The present Medicare / Medicaid programs would continue to be supported through all health insurance plans in the nation.

Should any constituent make any major commodity purchase and the federal sales tax is more than \$ 1,001.00 all of the commodity sales tax over \$ 1,000. Would be deposited into that constituents social security account #. The Social Security department would automatically issue a new card with a SH added to that persons Social Security original number. EXAMPLE: 123-45-6113 SH * Social Security plus free Health care.

When the participant have the health care plan going into their own Social Security fund, the government would add to the private health care use to assist the candidate that paid into the commodity sales tax system. Of course it is up to the expert health care collaborators to convince our government that the Social Security and free healthcare commodity sales tax is the best way to fix two major problems at the same time? It is much easier for the poor and the rich to pay a nickel on every dollar into this system, than it would be to depend and hope for a 4-cent marginal profit paid as a Dividend from the stock market ventures. The guarantee is a WIN WIN SITUATION WITH A COMMODITY SALES TAX THAT EVERYONE WILL PAY. Send this Article to each lawmaker you know that represents you to the president, the Congress and the House of Representatives in the capitol as well as your own state officials in

government. Help our future generations who will need much more benefits to live in retirement than the pittance of less than \$ 700. Per month the average American receives today. It is your duty to voice your opinion as long as we are a free nation. Any questions e-mail or write to the address on the front page. Coming soon book # 2: "Lord I ask U! How Can i Live?" \$ 14.95 © 2005 individually printed, or read it through my e-mail for the same price. Just mail me a check of \$14.95 plus 7% Florida sales tax =s \$ 16.00 For a postal book add \$ 5.00 for shipping and handling. Make all checks or money orders to the Gargiulo foundation educational trust fund. A family for profit organization.

Through e-mail we will send ten full pages once a week. Until you receive all 200 pages of Book # two. As a bonus at your email request I will email Book # 1 TO YOU FREE: "Lord How Can i Live" © 1975 & 2002

Both books tell miracles about a carnival man who was crippled from the neck down, very religious, an 8th grade drop-out and is very successful in raising four children that are well educated with full Prosperity. It tells about his fights with his Catholic Churches, & the underworld, while falling through all of the cracks of, government laws for health care, Vocational Rehabilitation for jobs & finally becoming an Activist for all domestic issues that ultimately is designing the Americans with Disability Act. Author Tony Acro Gargiulo Sr.

<u>A BETTER WAY TO SHORE UP SOCIAL SECURITY</u> <u>AND FREE HEALTH CARE</u>

WE THE CONSTITUENTS WILL NOT WIN THE BATTLE TO SAVE SOCIAL SECURITY from depletion. This is where our present president is decisively taking a 70-year-old program out of the government's hands and placing it into the private sector. By beginning the imploding of destruction of a Highly successful SAFETY NET FOR RETIRED FOLKS LIKE YOU AND I, The hill will tear down its walls by chipping away the entire social security program each year after Bush leaves office.

Our government college educated and many with doctorate paper value continue to destroy the walls of domestic protection for our future generations. This is happening because a minority of Americans refuse to get off their butts to go out and vote, with the minority of Americans that care. I am 73 years of age. I am the fighter that woke up America by investing \$ 20,000. To print and hand out ONE MILLION NEWSLETTERS THAT CREATED ACTION FOR ALL DOMESTIC ISSUES SINCE 1980.

We need to get the attention of all Americans who really are concerned to keep America FREE from POVERTY and to keep a roof over the heads of the indigent, the elderly and the disabled. As well as every future youth in this nation. Every day many new suggestions are being written to assist the president in giving away the 8 trillion dollar Social Security program and place it into the Stock Market.

THE LAW 4 PROFIT

In America we say, "there is always a better way to build a mouse trap" Perhaps the future will prove President Bush to be right. But to secure his gamble from freeing the government to reverse a perfect attendance record, (payments of Social Security never missed one week in 70 years pay out to the retired.) and place that program completely in the hands of the money sector of profits. This is the most dangerous gamble that the republican Administration is taking in the History that includes all wars to keep America free.

Our governments in the past wars and including Iraq have borrowed the money from the public tax support programs and never paid it back. President Clinton could have paid it back with the democratic surplus in the budget, but the former brilliant president Clinton opted not to do it. Now all Americans are concerned about the Social Security system. I am not ashamed to tell my story. Born with Scoliosis, and at the age of three (1935) the year President Roosevelt established Social Security, I contracted Polio from the neck down. We lived in poverty during the Stock market and banks crash.

Beginning in 1942 the year I was released from the hospital to live in Connecticut with my family, I decided at the age of 16, to go into the world alone to earn a living, without an education. Jobs were paying 60 cents an hour. Pink slips in the pay envelope were the manufacturers system to

terminate we the employee. Rooms in the YMCA COST SIX DOLLARS A WEEK and I lived on six dollars a week for food, clothing and, transportation. Social Security was the best payment taken out of my checks for the next twenty or thirty years when I found a job to pay the Social Security. During the same years the word Physical Rehabilitation began to be the program for people with disabilities and the commercial industry commercialized with Rehabilitation to farm out piecework and created slave labor for disabled shut-ins. We were paid \$12.00 per week. Today in 2005, the same slave shops continue to pay \$12.00 a week! Wake up America it is time to investigate Vocational Rehabilitation programs nationwide.

Goodwill, & the Salvation Army became commercial retail stores and is still under the tax-exempt banner. All organizations that apply for a 501C (Tax exempt number to go non or not for profit,) should also be re-evaluated to comply with the Law 4 Profit status. The Law 4 Profit status means that all non or not for profit organizations that hold more than \$ 100,000. In their bank accounts, and own real estate with building structures, must begin to service their community with NEW INDUSTRY HIRING EQUAL MULTICULTURAL EMPLOYMENT.

All of the major industries that employ over 1,000 employees that have multiple chain stores or franchise's must design a neighborhood civic association community business; before building a second chain of 10 stores in this nation. By doing this the TEN-STORE NEIGHBORHOOD WALL WILL STOP MAJOR UNEMPLOYMENT DISASTER IN AMERICA. The judicial system must play an important part with all Legislative state branches to apply the law 4-profit program. The law 4 profit program will protect national crashes to happen when corporation begin to destroy all mom and pop industries with massive stock takeover programs.

Our capitalistic system is beginning to IMPLODE inside our world marketing structures. The national congress should stop major corporations from going overseas to manufacture products and return the product to America, and still receive tax breaks. The industries that have a history (such as Wal-Mart) that was established from a mom and pop idea should be penalized for destroying jobs inside America. Let the outside manufacturer pay the tariff double for infringing on the America job status quoi. The same goes for the takeover of chain stores inside America. All of this coercion is prepared to design windfall profits for the

corporations that swallow HUGH PROFITS WHEN THEY BANKRUPT AMERICAN SOCIETY.

Shore up Social Security through Life insurance Annuities

The president's idea to allow personal investments of the Social Security system is not a good idea for those who will receive the check in their retirement days. Assuming that President Bush gets the Congress to pass his agenda that Ultimately will abolish Social Security and replace Social Security with individual retirement stock investing, there is a much better guarantee through the life insurance annuity programs. New policies by the knowledgeable insurance groups should prepare a proposal to President Bush because they automatically will jump on this Hugh gravy train after the new rules are, in place. Why wait until the damage is done to Social Security? Instead, President Bush should approach the industry to design the better proportion of the full annuity to be placed in their account at the Social Security retirement age that is due to change because of the presidents new planning. Many insurance companies are already into the Annuity program system and it works for the living retiree. The difference is that when the retiree dies, the policy ends.

Insurance companies can redesign a annuity program that will compensate the insured for ten extra years after death to transfer those ten years into the heirs Social Security account. In the long run, The insurance companies will gain new customers that wish to protect future generations to receive a helping hand because our government eventually will phase out the seventy year old Social Security System that has never failed to make its payments due to the constituent.

Anthony J. Gargiulo Sr.

Hattey Jayind Sor



Speaker Resume

Ira Stewart Wiesner is a nationally recognized elder law attorney and founder of Advocates in Aging, a multidimensional elder law firm in Sarasota, Florida. He is former President of the National Academy of Elder Law Attorneys as well as Past Chair of the Elder Law Section of the Florida Bar. Ira is Board Certified as a Specialist in Taxation as well as Elder Law. He is a Fellow of the National Academy of Elder Law Attorneys as well as of the American College of Trust and Estate Counsel. He is a past member of the Florida State Long Term Care Ombusdman and frequent lecturer, consultant and resource on issues of long term care financing and aging.

EDUCATION

STATE UNIVERSITY OF NEW YORK AT BUFFALO:

B.A. in political science and philosophy,

cum laude, 1973.

Juris Doctor, John Lord O'Brien School of

Law, 1976

UNIVERSITY OF FLORIDA:

LL.M. Master of Laws in taxation, 1978

UNIVERSITY OF SOUTH FLORIDA:

Graduate Certificate in Gerontology

(currently in pursuit)

Graduate Certificate in Hospice, Palliative

Care and End of Life (currently in pursuit)

NAROPA UNIVERSITY:

Transpersonal Psychology, M.A.

(currently in pursuit)

PROFESSIONAL

ADMITTED TO BARS: State of New York, 1977; State of Florida, 1976; United States Tax Court, 1978

FELLOW of the NATIONAL ACADEMY OF ELDER LAW ATTORNEYS FELLOW of the AMERICAN COLLEGE OF TRUST AND ESTATE COUNSEL

BOARD CERTIFICATIONS:

The Florida Bar: Taxation and Elder Law The National Elder Law Foundation: Elder Law wiesner associates

Advocates in Aging

a law firm

Estate & Retirement Planning Counseling Seniors & Persons with Disabilities

Ira Stewart Wiesner

941-365-9900

MEMBER:

- Florida, New York and Sarasota County Bar Associations
- President National Academy of Elder Law Attorneys, Inc. 1996-1997
 and Chair of Public Policy Committee
- Past Chair, Florida Bar Section on Elder Law
- Formerly Adjunct Professor of Law, Stetson University College of Law
- Member Southwest Florida Estate Planning Council
- Formerly ACLF Residents' Consumer Advocate Member of the Florida State Long Term Care Ombudsman Council
- Formerly Attorney Member of the District VIII Florida Long Term Care Ombudsman Council
- Past Director, Sarasota Human Services Planning Association, Inc., Temple Beth Sholom,
 Sarasota-Manatee Jewish Housing Council, Inc., Sarasota-Manatee Jewish Federation, Inc.
- Currently Director of Academy of Florida Elder Law Attorneys

PUBLICATIONS, PRESENTATIONS AND OTHER

- "Coordinating Pension and Insurance Benefits to Preserve Financial Security," 2nd Annual Symposium, National Academy of Elder Law Attorneys, San Diego, CA, May 1990
- Co-chaired "Florida Day" at 3rd Annual National Academy of Elder Law Attorneys Symposium, Orlando, FL, May 1991
- "Coordinating Pension Benefits to Preserve Financial Security," 3rd Annual National Academy of Elder Law Attorneys Symposium, Orlando, FL, May 1991
- Coordinator "Large Estate" presentation at 1st Annual National Academy of Elder Law Attorneys, Elder Law Institute, San Antonio, TX, Nov. 1991
- Chair, National Academy of Elder Law Attorneys 4th Annual Elder Law Symposium, San Francisco, CA, May 1992
- Co-chair and presenter on "Introduction to Elder Law" program, National Academy of Elder Law
 Attorneys 4th Annual Elder Law Symposium, San Francisco, CA, May 1992
- "Asset Transfers, Trust Availability and Estate Recovery Under OBRA "93:
 Statutory Analysis in Context," Presentation to National Academy of Elder Law Attorneys
 3rd Annual Elder Law Institute, St. Louis, MO, Nov. 1993
- Speaker, National Health Underwriters Association, Annual Symposium, New Orleans, LA, June 1994
- Panel moderator, National Association of Health Underwriters, Advanced Estate Planning Seminar, Huntington Beach, CA, July 1994
- Presenter on "Elder Law: The Emerging Practice", State Bar of Nevada, April 7- 8, 1995, Las Vegas, NV
- "OBRA '93 and Medicaid; Asset Transfers, Trust Availability, and Estate Recovery Statutory Analysis in Context," Nova Law Review, Winter 1995
- Recipient, 1996 Elder Law Advocacy Award, Stetson University College of Law, Center for the Study of Law and Aging

HONORS

- Recipient of the First Theresa Award of the Theresa Foundation, 1995
- Witness before Older Americans Caucus, Chair Rep. Joseph P. Kennedy, III
- Guest on *Today Show*, Bryant Gumbel, October 1996
- Developed National Elder Law Week, 1996
- Developed NAELA Unprogram
- Contributing Editor, Dictionary of Eldercare Terminology, Feldesman
- Recipient, The Charlotte Brayer Public Service Award of the Elder Law Section of the Florida

FACTS AND TRENDS IN THE PAYMENT OF NURSING HOME CARE IN FLORIDA

The Truth Behind the Urban Myth of the Crisis in Medicaid Estate Planning

Total Number of Nursing Home Residents, 200	3	71,987
Number of Residents with Medicaid as Primar	y Payor	44,200
Percentage of Nursing Home Residents on Med Nationally 66.3 State Rank	icaid 40	61.4
Nursing Home Facility Spending per capita Nationally State Rank	\$125 \$154 32	

During the period 1998-2003 the following trends occurred:

Nursing Facility Residents increased by 5.1% while beds only increased by .6%.1

In 1996, Joshua Weiner² of the Urban Institute, noted that the only direct, empirical data³ addressing the issue of asset transfers for the purpose of Medicaid qualification showed that although some clients in transferred assets (49 out of 403) three quarters of those people transferred less than \$75,000 and of those, 26 were denied Medicaid or withdrew their applications. Of the 7/403 applicants who had transferred over \$100,000, 6 were denied. This would suggest that, at least in this study, only 12% of the applying population had transferred assets and of these, 55% were denied Medicaid.

Weiner proposed that beyond this study, the incidence of asset transfers are low. To prove this he postulated three tests for verification:

First: Older persons cannot transfer large amounts of assets if they do not have large amounts to transfer. In his study, he noted that the Survey of Income and Program Participation calculated that 3/4 of nursing home patients had less than \$50,000 of non-housing assets.

This is comparable to the current Florida picture.

Second: Weiner suggested that if large and rapidly increasing

numbers of the elderly are transferring their assets, then the number of Medicaid nursing home beneficiaries should be rising rapidly. In fact, the number of Medicaid nursing home beneficiaries is increasing slowly and only slightly faster than the number of nursing home beds. Nationally, between 1990 and 1993, the average annual compound rate of increase in Medicaid nursing home beneficiaries was 3.3%, with 1992 as an aberrant year.

In Florida, the number of Medicaid beneficiaries has stayed almost constant over the last 7 years!!!

1996	1998	2002	2003
39,378	43,843	43,406	44,200

This is less than 2% growth compounded annually!!

Finally: Using the methodology in a 1995 study by Liu and Moon, he showed that, in the case of Florida, if one takes the 2% annual growth, that amounts to an average of only 854 new Medicaid nursing home beneficiaries per year.

Even if each of them transferred their average non-home equity of \$30,000, which is rarely, if ever, what happens in reality, that would amount to 201 days of Medicaid coverage that would have otherwise been paid for (\$30,000/\$149 per day). That represents a increase in the total number of Medicaid paid for days of 201 x 854, or 171,654. This represents 1% of the total number of Medicaid paid for days of 15,843,190. Clearly, this is not where the Medicaid budget problem lies. But claiming that it is millionares hiding thier assets to get Medicaid is an easy play to deflect attention away from the real motivation to make it more difficult for seniors and the chronically ill and disabled to cover the costs of nursing home care.

Trends in Median Household Net Worth by Age of Household Head

AgeL + + '; b	1984	1988/47/4 ***	19910	2000
65-69				
TÖTAL NET WÖRTH	88,151	96,834	104,354	114,050
EXCLUDING HOME EQUITY	28,718	31,879	33,345	.27,588
70-74				
TOTAL NET WORTH	79,476	95,249	92,793	120,000
EXCLUDING HOME EQUITY	24,732	32,679	25,943	31,400
75 and over				
TOTAL NET WORTH	72,920	71,330	76,541	100,100
EXCLUDING HOME EQUITY	22,584	21,830	22,866	19.025
	12 (12) 11 (12)			

Sources: Eller, T.J. 1994, "Household Wealth and Asset Ownership, 1991." Current Population Reports, U.S. Bureau of the Census.

Ergle, J. 1990, "Household Wealth and Asset Ownership, 1988." Current Population Reports, U.S. Bureau of the Census.

"Net worth and Asset Ownership of Households: 1998-2000" Current Population Reports, U.S. Bureau of the Census.

- 1. AARP Public Policy Institute, Across the States, Profiles of Long-term Care: Florida, 2004.
- 2. Weiner, J., Medicaid Asset Transfer and Estate Recovery: How Much Money To Be Saved?, Draft June 5, 1996.
- 3. General Accounting Office, July 20, 1993, GAO.HRD-93-29R).

This report was prepared by Wiesner Associates, Advocates in Aging, 1800 Second Street, Suite 870, Sarasota, Florida 34236, (941) 365-9900. Please contact us with any questions.

MEDICAID LONG TERM CARE ELIGIBILITY REFORM PROPOSALS February, 11 2005

On January 11, 2005, Governor Bush proposed a conceptual plan to completely change the way Medicaid works in Florida. Few details were provided, but the overarching themes will certainly impact the frail elderly and disabled in Florida.

According to the Governor, his proposed changes to Medicaid in Florida are neither "timid" nor "tentative." His plan "fundamentally transforms" the health care benefits for our state's most vulnerable residents. The question is not whether change is appropriate, but rather how it is achieved.

We applaud the Governor for starting the process of discussion and input from all affected people in Florida. However, this process should continue through a measured, humane approach to the needs of the elderly and disabled by openly and honestly discussing these ideas with Floridians.

Any plan to request a waiver of stringent federal laws protecting the frail and needy should have been first brought to the attention of all Floridians as well

as the legislature, for their input <u>before</u> a plan was submitted to the federal government and before the legislature considered the appropriateness of such broad legislative restructuring effecting so many of its citizens. More details are needed about the Governor's plan before a full understanding can be had and specific plan elements can be addressed.

In April of last year, a letter to the Governor, signed by over 70 concerned advocacy groups and individuals and copied all to Senators and Representatives, urged the Governor to disclose the details of these proposals and provide the opportunity for statewide public hearings. Today, we are presented with a sketch of how his proposals will apply to some of the effected populations, and to others, specifically the elderly and disabled, we are still totally in the dark as to what is planned. The details have been kept secret, and we fear that there are grave consequences to our citizens lurking in the shadows. Its time that the plan be brought out in to the sunlight.

As a result, questions abound:

- 1. When the elderly person spends all of their allotted Medicaid money, and then has to seek financial assistance from the proposed "catastrophic" fund, will there be enough money to pay for everyone who may need to access that fund?
- When the financially needy young disabled person needs long term care after a catastrophic accident, how much Medicaid money will be available to her to fully meet her lifetime needs?
- 3. Will managed care organizations work to minimize benefits to their plan members in order to increase their own profits? Will this be in keeping with the Governor's plan for increasing competitiveness? Just how competitive will it get and who will be caught in the middle?
- 4. How will basic elderly long-term care needs be met if state revenues are reduced, such as with the elimination of the intangibles tax?

While the Governor's plan has as its hallmark "flexibility" in the provision of services, and we agree flexibility is important, it cannot come without certain fundamental issues being adequately addressed:

First and foremost is the essential requirement that due process be afforded to all effected persons. with starts assurance that changes in eligibility criteria should be prospective only and sufficient time must be provided to afford due process to prospective applicants. Further, the system must provide due process to address issues of eligibility, services, access and compliance. Finally, regardless of the delegation of the processing of Medicaid to private companies, independent forums to appeal denials must be included.

In this regard, gatekeepers for a long term care system, in particular case managers and eligibility specialists, <u>must</u> be required to have the education, training and experience necessary to apportion care. They must be required to act with regard for the needs of the frail elders and the caregivers who will be at risk of serious injury or death if their decisions are mechanically made for profit motives alone.

Capitation of services and funding should not be a component. Frail elderly residents will be put on waiting lists and denied services until a "space" becomes available. People in need cannot endure waiting lists and will be forced to live in inappropriate settings (at home without sufficient home health care or safety supervision, hospitals, or mental health facilities). The costs of necessary care will be unfairly shouldered by

other parts of the community.

The legislature should seek and support existing and new efforts to provide financial, physical and emotional support for caregivers because such measures permit longer caregiving in the home and prevent the onset of health problems for the caregiver.

The legislature should vehemently oppose any attempt to alter Florida's constitutional homestead protection from creditors and/or federal laws which exempt the value of homestead property as an eligibility criterion because of the potential for its additional punitive effect on frail elders and the chronically ill.

The balance of my remarks today will <u>not</u> focus on the specifics of the Governor's plan, even as far as its details have been disclosed so far. Rather, they will deal with the aspects of the proposals for which no details have been disclosed and for which there is no forum for public debate to take place. It is a hidden agenda that will impact a significant portion of the frail elderly population of our State, those suffering long-term chronic illnesses.

It is the population of chronically ill persons over the age of 65 who are already unfairly disadvantaged because the costs of their health care are not covered by Medicare. The most common chronic illnesses for persons over 65 are Alzheimer's disease and other forms of dementia, Parkinson's disease, post-stroke syndrome, diabetes, Lou Gehrig's Disease, MS, neurological disorders, emphysema, COPD, osteoporosis, and crippling

arthritis. The mentally ill and the developmentally disabled who previously had a limited life expectancy now become additionally compromised as a result of the aging process and their aging parent caregivers now predecease them, resulting in the need for long-term care assistance. There is a common misconception which rises to the level of prejudice that these needs do not constitute health care and therefore should be provided by family members at no cost to the health care system.

This population suffers from a public policy relating to chronically ill elders that is fundamentally flawed. We have relegated our chronically ill seniors to a situation where they have no alternative but Medicaid to prevent impoverishment from the costs of long term care. Most families needing long term care feel defeated by having to apply for "welfare" after years of working and saving. Many are children of the Great Depression and are World War II veterans, our so-called Generation." The costs of long term care - regardless of the setting - are just as financially devastating for the chronically ill as for those who are treated for acute illnesses which are covered by Medicare. The assignment of the long term care benefit to Medicaid in 1965 was never intended to create a disparity between the health care coverage of acute and chronic illnesses for the aged and disabled.

The primary victims of this approach are women: women over the age of 70, whose husband's are lost to them as companions and spouses because of the devastation of chronic illness, who lose the benefit of their spouse's social security and pensions to the costs of nursing home

care, and then have to live for an extended life expectancy without the economic means to maintain themselves with dignity, and without themselves having to become financially dependent on the State.

When I began my elder law practice in 1984, [tell story].

Now, we are going back to that approach. The rise of divorce among the elderly is up 48% since 1990. This is compared to 20% rise for the entire population over age 18.

In many circumstances, both spouses are still competent and it is the ill spouse who requires very expensive medical or nursing home care insists on divorce as the only way to give his wife a chance. Clients are emotionally devastated by the necessity to make the decision to go this route at a time when they are most vulnerable. For a society that professes to support the institution of marriage, this is a sad and desperate situation.

As a society, our challenge is to stay focused on our ends, and not be overwhelmed by the difficulties of achieving those objectives. Our collective responsibility is to assure that our citizens receive needed health care when they haven't the financial capacity to acquire them.

The goal should be to provide the services necessary to those in need; not to spend the least amount we can without regard to scope of the needs. Unfortunately, the

Governor has stated that:

"In the transformed Medicaid program, setting the spending level is the primary governmental function.", Florida Medicaid Modernization Proposal, page 5.

Under this approach, the priority is not our citizens; it's the budget. It's the proverbial tail wagging the dog. You can correct this mis-focus.

When the Medicare Bill was signed into law, President Johnson was clear about our commitment to protect older American. He said:

"No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime, so that they might enjoy dignity in their later years. No longer will young families see their own incomes and their own hopes, eaten away simply because they carrying are out their deep obligations to their parents, and their uncles and their aunts. And no longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country."

Senators, July 30 will mark the $40^{\rm th}$ anniversary of those remarks. Your actions and deliberations over the coming months will determine whether we remain a progressive society.

The Chinese word for crisis is composed of two characters, one signifying danger, the other opportunity. I used to believe that referred to the external circumstances, but I've come to understand that this refers instead to how we choose to respond to the challenges we face. Do we act with shortsightedness and defensively? Or do we stay focused on our goals and act boldly and courageously. Crisis, if it exists, is the test of our metal and your leadership.

Thank you.

Comments to Medicaid Hearing, February 11, 2005

- I am Dave Rogoff, Director of Health and Social Services, Hillsborough
 County.
- Hillsborough has a history of "stepping up to the plate"

With the authorization and partnership of the Florida Legislature, we have operated Hillsborough HealthCare – A public / private partnership since 1991.

- > Payor when all else fails.
- > History of primary care, disease management based.
- > Aging services diversion programs.
- ❖ Like other government and private health care providers, we are struggling with rising costs and must look at what we do.
 - > But the "glass is half full, not half empty".
 - > The challenge, that we are up to, is to figure how best to use what we have.

Comments to Medicaid Hearing, February 11, 2005

- Yesterday, we were talking with the AHCA Secretary, Alan Levine:
 - > Since we all face the same problem, challenge is to work together.

> Why:

- The challenge is not to shift costs around, it's to make health care seamless.
- For example, as a payor of what no one else covers, we do not cover low-income pregnancy and children, which is covered by Medicaid or KidCare services, Medically needy under Medicaid but:
 - We spend an incredible amount of time over jurisdictional disputes.
 - Examples:
 - What happens when a woman being seen in our plan for Gyn issues is found to be pregnant,
 - What happens when we find that a person we cover is actually
 Medicaid eligible ?

Comments to Medicaid Hearing, February 11, 2005

- ❖ Therefore, as we enter into a period where we, like the State, and like the feds are addressing what we can do, I leave you with these comments:
 - We welcome the opportunity to work with the State in addressing how we can jointly deal with access to health care.
 - ➤ It may be a cliché, but I am reminded of the picture that I have in my office of a dog sled – an interest of my younger years:
 - Yes, it is true that if you are not the lead dog, the view never changes.
 - In dealing with health care, we in Hillsborough have been a lead dog and the state of Florida also is looking to be a leader.
 - You only have challenges when you want to be a leader.
 - We believe that only by working together counties that do want to be leaders, the State, and even the Feds – can we address these challenges.



Business: (813) 301-7344 Fax: (813) 276-8727 RogoffD@HillsboroughCounty.org

DAVID P. ROGOFF
Director
Health and Social Services



Public Comment Medicaid Modernization Proposal Offered by Sandra Sroka February 11, 2005

Thank you for holding these public forums and giving us the opportunity to address elements of the Governor's Medicaid Modernization Proposal. Although I am involved in a number of state and local disability serving organizations such as the Florida Developmental Disabilities Council Healthcare Task Force, the Florida Alliance for Assistive Services & Technology, the Hillsborough County Alliance for Citizens with Disabilities, and the Mid-Florida Chapter of the MS Society, and professionally work as the ADA Liaison for Hillsborough County, I am here today speaking as a concerned citizen with a disability.

While recognizing the importance of containing costs, health care is essential for persons with significant disabilities who are struggling to achieve self-determination, competitive employment, inclusion and education. The information released by the Governor prompts more questions than it answers. It does not have specifics as to how the measures will be implemented and there are no dollar amounts noted. Questions are raised about the potential impact to persons with disabilities, how the changes will be implemented, and what safeguards there are for people with developmental disabilities. To fully understand the impact of this proposal the following questions must be addressed:

- 1. Is this proposal going to cap the federal Medicaid funding we currently receive? Our state receives 59% of matching dollars from the Federal government for every dollar spent by Medicaid. The federal match provides flexibility in meeting increased needs of the uninsured or vulnerable citizen. This federal sharing partnership aids Florida in alleviating a large financial burden that otherwise would have to be met through state revenues or be passed on to local communities.
- 2. Currently there is a scarcity of providers due to the low levels of reimbursement. How will the proposal ensure the participation of providers?
- 3. How is this proposal going to impact individuals with disabilities who may need services beyond the basic Medicaid services so that they may avoid future medical deterioration, maintain quality of life, and be enabled to seek competitive employment?

Persons with significant disabilities are most likely to have chronic or complex health conditions. They may not be able to readily participate in preventive care or "compliance" programs. Will these elements of the proposal punish these individuals with chronic conditions?

- 4. What does the cap on catastrophic coverage mean for these individuals with significant disabilities?
- 5. How will previous legal mandates governing provision of certain assistive technology for persons with disabilities under Medicaid be addressed and provided?

- 6. When the governor's program speaks to "Choice", what does that really entail? Is it a choice between providers of care or choice between HMO's?
- 7. What provisions will be made for education to help consumers navigate this new complex system?

Persons with intellectual or cognitive disabilities especially may be placed in jeopardy if they are not given clear and appropriate assistance in navigating any new system of health care.

8. What will the premiums be for persons with disabilities?

Persons with disabilities and elders consume the largest share of the Medicaid services and associated costs, but this population may be least able to contribute toward premiums because of their low-income/fixed income status.

9. Has a cost/benefit analysis been completed to determine that this new program will really save money?

I hope that the Governor's office and our State House and Sensate representatives carefully consider and address these concerns in any Medicaid reform proposal.

Thank you again for this opportunity to share my thoughts, concerns, and suggestions to achieve a proposal that best addresses the needs of all of Florida's citizens, especially the most vulnerable of Floridians.



Healthy Start Coalition Of Hillsborough County, Inc. February 11, 2005

Healthy Start Coalition Of Hillsborough County Testimony

Good Afternoon. My name is Hillary Frank Aubin and I am here today representing the Healthy Start Coalition of Hillsborough County. Thank you for the opportunity to provide input on the topic of Medicaid Reform.

Since the initiation of our Healthy Start Coalition the people of Hillsborough County have enjoyed major accomplishments in the key areas of Maternal and Child Health:

- Infant Mortality has declined by 30%;
- The number of Very Low Birth weight Babies has declined by 11%;
- The number of repeat births to teenagers has declined by 37%; and
- The number of Infant deaths within the first month of life has declined by 28%.

However, these figures represent more than just compelling statistics. These figures represent the improvement in individual's lives and in the long-term a better, more successful society.

In the world of Medicaid and Medicaid-Reform they mean significant cost savings. The Healthy Start Coalition recognizes the need for Medicaid reform and strongly desires

to work with the legislature to offer ideas which we have successfully implemented that save money for the state.

We know that every time we help a Medicaid-covered mother get through pregnancy without complications we save thousands of Medicaid dollars.

Every Medicaid-covered baby that we get to full term and keep out of the neonatal intensive care unit saves tens and sometimes hundreds of thousand of Medicaid dollars.

Every time we help keep a Medicaid-covered infant healthy and out of the Emergency department we save hundred's of Medicaid dollars.

Healthy Start accomplishes these savings by strong, individual educational interventions in the areas of child birth, parenting, breast feeding, nutrition and in-home nursing support.

We urge you to explore and further implement our proven programs to transform Medicaid from a program caring for the sick to one that is sustaining the healthy.

Reduce Rapid Growth of Medicaid Expenditures Saving Medicaid \$\$\$\$\$\$\$\$\$

PPEC is the most cost-effective, medically safe, and least restrictive community-based service delivery model for special needs and technology dependent children.

PPEC is the most cost-effective alternative to Private Duty Nursing (PDN).

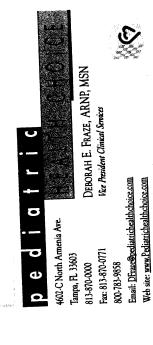
PPEC offers an average savings of 48% over Private Duty Nursing (percent savings based on per child/year; 5days/week/up to 12hrs/day)

➤ Average savings for PPEC services is 42% over LPN PDN Sample: PPEC annual costs-\$41,613/child/year

LPN annual costs- \$72,633/child/year

Annual savings/child-\$31,020

➤ Average savings for PPEC services is 54% over RN PDN PPEC annual costs-\$41,613/child/year RN annual costs-\$90,792/child/year Annual savings/child-\$49,179





Shriners Hospital for Children is a 58 bed facility located on the USF campus, Tampa Florida.

We are part of a 22 hospital system serving children with orthopaedic conditions and burns. These hospitals are geographically located to serve the children all over USA, with one hospital in Mexico City, Mexico and one hospital in Montreal, Canada

Our hospital located here on the USF campus serves the entire state of Florida and parts of Southe Georgia.

In 2004 Shriners Hospital provided an estimated 45 million dollars worth of excellent orthopedic and burn care to over 11,683 pediatric patients from the state of Florida.

We serve the pediatric orthopedic population with such diagnoses as spina bifida, cerebral palsy, scoliosis, congenital limb anomalies, spinal cord injury, feet, hip and spine disorders and children status post traumas and burns.

Our services that are provided at no cost to the families, state or insurance companies include surgeries 896 for the year 2004, outpatient visits totaling 9,585. Rehab services that include physical, occupational and speech therapy 10,846 treatments for the year 2004. The fitting, fabrication and delivery of over 6000 braces and 250 artificial limbs. The evaluation, prescribing, measurement and fabrication and delivery of over 80-advanced wheelchair seating systems.

Shriners Hospital in Tampa employs 302 people. This group includes medical professionals, ancillary staff and researchers. As a teaching facility located here on the campus we are affiliated with local universities and impact hundreds of students with their internships, fellowships and rotations that affect their health-related careers. We have 300 community volunteers. We had a payroll of \$12,389,000 for the year 2004.

Our hospital contracts for local medical staff and diagnostic services totaled \$650,000. We have contributed five million dollars in vendor contracts. It is estimated that 40% of our patient population is jointly served by Shriners and Medicaid

Recent changes that have affected patients care have been the discontinuation of transportation services to our clients, and denials in the prescribing of seating —wheelchair systems.

The state of Florida has a willing partner providing millions of dollars worth of excellent care, free of charge, to children who otherwise would be receiving Medicaid funding for their care. We understand that the Florida Medicaid budget is under tremendous strain. It seems like the perfect opportunity for the State of Florida and the Shriners Hospital for move forward as a team, foster our symbiotic relationship and create an environment that would allow us to provide excellent care to this population in need. Thank you!

Contact Beth Dem (2)

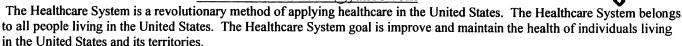
333

1917, 30

975 7116

HEALTHCARE SYSTEM FOR THE UNITED STATES

CONTACT WES HUFFORD AT ideas 1776-healthcare@yahoo.com W WW. am:+or. org



First Tier of Payments to Fund the Healthcare System

- All forms of income whether taxable or nontaxable will be subject to the Healthcare contribution, including social security, welfare programs, interest, dividends and pension distributions.
- Capital gains should be excluded from the assessment.
- By including all sources of income, people will develop a pride in themselves that they are contributing to the services being provided. A broad base tax will keep the tax low.
- Employers will match the employee contribution.

Healthcare Collection Agency (HCA)

- All healthcare taxes collected by employers or governments will be paid into the HCA.
- The HCA duty will distribute funds out to the political divisions under a predetermined method.
- The HCA will be responsible for the movement of funds between the states or counties.
- The political divisions will submit their final plan of operations to the HCA. The HCA's purpose will be to determine the effectiveness of operation and to prepare recommendations that the political operation may accept or reject.
- Federal and state governments will fund the HCA over five years for any unfunded liability of healthcare. The HCA will report the unfunded liability for public inspection.
- Existing funds and reserves of employers, unions, and insurance companies will exhaust their funds before their
 participants will be allowed access to the new healthcare system. After reasonable administrative costs, these funds
 and reverses may be contributed to the HCA The HCA will coordinate work with these other entities during the
 conversion period. The unfunded liability as determined by an actuary will be reported to the HCA and a payment
 schedule of not less than ten years can be negotiated.
- Healthcare system duty is to collect and report activities among all the designated divisions.
- The federal and state governments will tax industries or their products that cause poor health in individuals. These taxes will be turned over to the HCA. Example: The tobacco tax will be collected by the Federal and state governments and paid to the HCA. Because the tobacco tax will no longer be used for general funding of the government, the Indian reservations will have to assess the tax to their products.
- For individuals currently on the Medicaid program, the federal and state governments will continue to pay costs on those individual to the HCA during a ten-year phase-in period.

Political Divisions

- Each state legislature and governor will determine whether the state or the county will administer the Healthcare System.
- A political division could be a state, several states that share boundaries, a county, several counties sharing boundaries. No Political division can be split.
- The committee of elected officials and healthcare providers will discuss the system and to recommend changes.
- The political division will have the power to assess an additional tax for improving their Healthcare System.
- Because people may move, the HCA will coordinate transfer payments among the political divisions.
- The political division may hire a third party administrator to collect information and pay the healthcare providers.

Healthcare Providers

- Each designated political division will have the power to negotiate pricing with healthcare providers.
- The System will provide for payment to a healthcare provider within two weeks.
- Political divisions must be able to communicate among each other to collect information and to pay providers. HCA
 and State governments will mandate the use of a standardized coding system. The HCA will assign the healthcare
 codes, but HCA cannot deny the assignment of a code requested by a political division.
- Each political division will negotiate with providers for inclusion in the Healthcare System within its jurisdiction.
- Healthcare providers can negotiate with other political divisions to provide services.
- Because new procedures and methods may become available, miscellaneous codes divided among designated ranges
 will be available for pricing of the service. The political division may create the assignment of a code and price will
 be guaranteed until reviewed by the political subdivision.
- Healthcare providers can request binding arbitration for disagreements in the application of payment.
- Binding arbitration cannot be used to force the political subdivision to act.
- People moving into a political division from a division not providing certain services may have to pay for those services.



Good afternoon

Thank you for giving us the opportunity to introduce ourselves and speak about our concerns with the governor's Medicaid privatization proposal.

My name is Dianne Steele and I am from Vincent House.

Vincent House is an International Center for Clubhouse Development (ICCD) clubhouse for people living with a mental illness. We focus on a person's wellness, not their illness. We work to improve the lives of all our members, and to accomplish this, we formed an Advocacy Committee to review legislative issues of concern to people with mental illnesses. Of primary concern to the members of Vincent House regarding the governor's proposal, is the apparent lack of input from the people served. There are many suggestions that can be made to improve the Medicaid delivery system, if the people being served would have the opportunity to sit down at the table and offer their suggestions.

We collectively reviewed the governor's proposal and have many concerns. Here is a brief list:

- 1. <u>Medicaid Block Grant:</u> First and foremost, we feel the entire notion of a Medicaid Block Grant to a growing state such as Florida, and especially one with a growing elderly population, is an extremely risky proposition. We have all seen the failure of TennCare in Tennessee. Florida, with its continually aging population will not be able to keep up with the cost of nursing home care and medical care without a flexible plan. We do not know what the cost of healthcare will be in 5 years, nor do we know how many seniors will need nursing home care. Capping income from the Federal government at this time will likely result in either an excessive Florida taxpayer burden or much pain and suffering to the families of Floridians who will lose their health care coverage.
- Consumer Choice: Choice can be a double-edged sword. We are very concerned that this plan will offer so many choices that it can paralyze the process. Too many choices make it difficult to get through the decision making. Many people may find it more convenient to use the Special Personalized Assistance to make the choice for them, leaving them with no real choice.
- 3. Oversight Process:

 The oversight process is too vague. There appears to be little that will protect the consumer since the insurance provider is able to design the plan, choose who will be able to participate in their plan and reject anyone they find unsuitable. There is no guarantee that some current Medicaid recipients that use a lot of services will have any company willing to provide the care they need. In addition, there is no guarantee the insurance industry will continue to provide coverage at the level they originally established once the current Medicaid system is dismantled.

- 4. Long-term Care for People with a Mental Illness: Although the proposal speaks about long-term care for seniors, it is silent about longterm care for people living with a mental illness. Many of our members live in an ALF that accepts Medicaid for part of the payment. With the continuing decline in low-income housing, these people need to be assured they will be able to continue to live in their current residence.
- 5. **Cap on Catastrophic Coverage:** The proposal mentions a maximum benefit but does not define an actual dollar amount. A cap on coverage means many people are likely to run out of insurance before they run out of illness. To make an informed decision about changing to a privatized system, it must be known what the cap will be and what will happen to people when they reach the cap on their health care coverage. This is truly a life and death situation.
- 6. Excessive Administrative Costs: The administrative costs of monitoring such a program will prove to be outrageous. Who will monitor the changes in insurance companies, employment and other factors that will affect qualification for health care benefits. The special personalized assistance, if done correctly, will be another added financial burden.

Thank you again for allowing us to present our concerns. The members of Vincent House appreciate your time and we hope you will keep these thoughts in mind as you prepare to make changes to the Medicaid system. Remember, you have our lives in your hands.

Thank you.

Vincent House Advocacy Committee Carol Jackson Clyde Kobayashi Rand Pierce Carey Shannon Dianne Steele

The would like to be of assistance by being at the table to discuss warp to reform Medicaid, He can be reached at (727) 521-2426 Thanks so much! Draine Stelle

Shop (Casey's Café), Gardening and Plant Care.

Business Unit:

Member Statistics, Attendance, Daily Newspaper, Quarterly Gazette, Financial Reports, Hidden Treasures Thrift Shop, Outreach to Members.

Member Services Unit:

Job Development and Placement, Transitional Employment (TE), TE Statistics, Member Bank, Benefits Planning, Housing & Education Linkage, Community Support and Assistance, Advocacy, Enrollment and Orientation, Florida ICCD Clubhouse Coalition

Evening and Weekend Activities:

Evening and weekends are time for fun. This is an opportunity to meet with other members to celebrate accomplishments and develop personal relationships.

Holidays:

All major holidays are celebrated on the actual day they are observed.

For more information:

Call (727) 521-2426
or visit us at:
Vincent House
in Buccaneer Plaza
6715 49 Street North
Pinellas Park, FL 33781

"The Clubhouse Guarantee"

A Guaranteed Right To a Place to Come

A Guaranteed Right ... To Meaningful Work

A Guaranteed Right ... To Meaningful Relationships

A Guaranteed Right ... To a Place to Return

Along with rights, members are encouraged to accept responsibility for their lives and determine for themselves what will bring them fulfillment.

Vincent House is based on a philosophy that people can and do recover, and that "everyone deserves the chance to be successful."



"Celebrating Recovery
Through Work"
6715 49 Street North
Pinellas Park, FL 33781
(727) 521-2426

...a membership community promoting vocational and social well-being.

" People must believe in each other, and feel that it can be done and must be done; in that way they are enormously strong. We must keep up each other's courage."

Vincent van Gogh



Vincent House

Vincent House is a vocational and social recovery program for adults that experience a mental illness, based on the ICCD Clubhouse Model.

The first clubhouse, Fountain House, was originally formed in New York City in 1948. Currently, there are more than 300 ICCD clubhouses around the world.

What is an ICCD Clubhouse?

The International Center for Clubhouse Development (ICCD) focuses on wellness send rebuilding of lives, not a person's illness. Participants are members, not patients. Members and staff work side-byside to operate every aspect of the clubhouse.

The Clubhouse Philosophy

Membership is voluntary and considered lifetime. The clubhouse is a place where members are treated with dignity and respect. They are wanted and needed by the Clubhouse Community. Membership participation is essential to the functioning of the clubhouse.

Membership is open to residents that are seeking recovery from schizophrenia,

bipolar disorder, and major depression with psychosis or other serious mental illnesses.

Transitional Employment

The transitional employment placement (TEP) component of Vincent House provides the opportunity for members to become employed in the community in part-time entry-level jobs at the prevailing wage. There are no interviews and no resume needed for TEP. A transitional employment placement lasts about 6-9 months. Members are trained on the job by Vincent House staff; people they already have a relationship with. After six months, the member moves to another TEP or may become independently employed. Another member learns the vacated position.

It is the responsibility of members to return to Vincent House when not working on their TEP for support, to build stamina and to contribute to the operation of the clubhouse. Every month members that are employed or interested in work attend a monthly employment dinner.

This is an opportunity to honor working members and to discuss work related issues.

Members may work any number of TEP positions, then move into independent employment.

What if I'm Not Ready or Don't Want to Work in the Community?

That's OK. You do not have to seek employment to join Vincent House. Some members come to develop friendships. The clubhouse is a place to meet other people with similar interests. It is a place to feel welcome and accepted.

The clubhouse provides the opportunity to gain self-esteem, confidence and stamina through the work of the club. This is accomplished through the pre-vocational (work-ordered day) program where members and staff work side-by-side, providing the core healing process. If wanted, members can seek employment in the community at large. Members may participate in every aspect of program design and implementation of Vincent House.

Work-Ordered Day

Members have opportunities to gain experience through the "work ordered day" at the clubhouse by working in the following capacities:

Food Service/ Horticulture Unit:

Menu Planning, Food Purchasing, Food Preparation / Safe Food Handling, Reception, Maitre'd, Dining Room Servers, Table Setting, Cashier, Snack





Advocacy Center for Persons With Disabilities, Inc.

Florida's Protection and Advocacy Programs

February 11, 2005

Senator Lisa Carlton, Chair, Senate Select Committee on Medicaid Reform & Rep. Holly Benson & Rep. Joe Negron, Co-Chairs, House Select Committee on Medicaid Reform 530 Knott Building 404 South Monroe St. Tallahassee, Fl. 32399-1100

Re: Florida Medicaid Modernization Proposal

Dear Chairpersons Carlton, Benson & Negron and Members of the House and Senate Select Committees:

Thank you for coming to Tampa to accept public input on this critically important issue.

The Advocacy Center for Persons with Disabilities is a not-for profit corporation authorized by, both federal law and the Governor's Executive Order No. 04-281, to advocate the legal, human and civil rights of individuals with disabilities. The Center's mission is to advance the dignity, equality, self-determination and expressed choices of individuals with disabilities. For example, in 2002 the Center developed a Blue Print for reforming & Enriching Florida's Services for Community Mental Health. Many of these recommendations have been implemented to enhance federal contributions.

Medicaid is this country's single most important program for meeting the health and long-term service needs of people with disabilities and for that reason the Center is committed to advocating the views and concerns of all people with disabilities in this forum. Over a half a million people in Florida who are on Medicaid, are people with disabilities. Any change to the state's Medicaid programs will therefore have a major impact on people with disabilities in this state.

☐ 2671 Executive Center Circle West, Suite 100 Tallahassee, FL 32301-5092 tel. 850.488.9071 fax 850.488.8640 toll free 800.342.0823 toll free TDD only 800.346.4127 2901 Stirling Road
Suite 206
Ft. Lauderdale, FL 33312
tel. 954.967.1493
fax 954.967.1496
toll free 800.350.4566
toll free TDD only 866.478.0640

The Times Building
Suite 513 1000 N. Ashley Drive
Tampa, FL 33602
tel. 813.233.2920
fax 813.233.2917
toll free 866.875.1794
toll free TDD only 866.875.1837

The Center appreciates the Governor's support for programs for people with developmental disabilities and we agree with many of the principles advanced by the Governor in this Proposal - empowerment, responsibility, access, and choice. We also commend the Governor and his staff for acknowledging the importance of home and community based alternatives for elders and people with disabilities and for recognizing that there are still not sufficient home and community based alternatives available in the publicly funded health care system. However, we have several concerns about the current Proposal and its impact on people with disabilities.

First, the Proposal provides few details about what will happen in long term care — a key area of concern for people with disabilities of all ages. The Proposal does little or nothing to ensure that seniors and people with disabilities get long-term care *where* they prefer to receive that care — including at home. Medicaid should not force people to live in institutions and the evidence is clear that it is **much less** expensive to serve and support people with disabilities at home or in community settings.

Second, the Proposal does not appear to guarantee full access to a sufficient safety net of critical health services. Regardless of the form this transformation takes, Florida must remain responsible for the quality and adequacy of services and must ensure that services are available in the amount, duration, and scope needed. Moreover, you must take steps to ensure that services are not limited arbitrarily and that people are not discriminated against based on their diagnosis, illness or condition.

The Proposal allows competing vendors to offer different packages. Our concern is not with the concept of flexibility per se, but rather with the substantial risks people with disabilities and the system itself could face as a result of private bureaucrats gaining control over access to primary care. If faced with barriers to access, people with disabilities can be expected to seek even more care from hospitals and emergency rooms at even greater expense to state and local government.

Third, if this system is to be capped, it will hurt Florida's neediest people with disabilities and people with extensive medical needs. In a capped system where the federal contribution is fixed, people with disabilities will be most at risk when private bureaucrats cut benefits and eligibility. Florida's population of elderly people and people with disabilities continues to grow. With each passing year, the number of people harmed by a capped system will increase.

Forth, the "enhanced benefits" provision of the Proposal is very difficult to understand, especially for people with disabilities. The Center and people with disabilities strongly support personal responsibility, but a system that requires compliance with extreme rules set by private health care bureaucrats is destined to cause harm and place disabled people at even

greater risk. You should not allow people to be penalized for failing to do things that they cannot understand and do as a result of their disability. Private health care bureaucrats have no incentive to accommodate people with disabilities. Rather than encourage responsibility, the existence of such a system will instead discourage people from participating at all.

Moreover, because the rehabilitative therapies and home and community based services are among those that must be "earned" under this Proposal and people with disabilities need these services at greater frequency, the "enhanced benefits" provision of the Proposal has a more disproportionate and punitive impact on people with disabilities than other Medicaid recipients.

Finally, the proposal fails to address the underlying causes of health care cost increases. Health costs are increasing faster than inflation and the increase is more pronounced in the private sector than in Medicaid, which is growing at a slower rate. Moderate income people lack access to health care. These are urgent issues in need of attention.

We urge the Legislature to consider our concerns as well as these alternatives:

Work to ensure that Medicaid is truly the payer of last resort – particularly as to people who are dually eligible for Medicare and Medicaid. In Florida, 43.5 % of Medicaid spending is for Medicare beneficiaries. Most of this spending goes to long term care and to drugs.

And work to increase the availability of home and community based services (including assistive technology, durable medical equipment and other supports). Every program in Florida that provides home and community based services has an extensive waiting list and those waiting lists are not fully representative of the unmet needs in the state. Florida needs to continue to rebalance the long-term care system to comply with the Olmstead community integration mandate and to employ cheaper and better models of delivering long-term services – without undermining core Medicaid services and protections.

Additionally, it is important to recognize that the current Medicaid system forces many recipients into poverty due to income and asset restrictions. Many disabled Social Security beneficiaries would try to work but for fear of losing their medical coverage. Last year's proposed "Freedom to Work" legislation would have permitted this population to "buy in" to the Medicaid system while earning a modest income, thereby creating an incentive for work and personal responsibility, rather than the disincentive that the current system promotes. Florida should join the 29 other states that presently are benefiting from having Medicaid Buy-in programs.

Clearly, there are many details to be worked out and we stand ready and willing to work with the Legislature and State of Florida to development a system of care with persons with disabilities that will be responsive to their needs and be responsible.

Sincerely,

Hubert A. Grissom

Interim Executive Director and General Counsel

GARNER.MICHAEL

From: Sent:

To:

Kelly, Alex [Alex.Kelly@myfloridahouse.gov] Tuesday, February 15, 2005 11:15 AM GARNER.MICHAEL; Moore, Mary Pat

Subject:

FW: (no subject)

From a speaker at the Tampa meeting, who did not get to finish.

J. Alex Kelly Majority (Republican) Office Florida House of Representatives 322 The Capitol

Office: (850) 488-1993 Direct: (850) 922-7731 Fax: (850) 487-4758

----Original Message----

From: Esg49@aol.com [mailto:Esg49@aol.com] Sent: Sunday, February 13, 2005 4:46 PM

To: Kelly, Alex

Subject: (no subject)

Medicaid testament

My name is enid gildar. I am a speech language pathologist from here in tampa. I greatly appreciate the opportunity to share my thoughts and concerns with you today.

The proposal for modernizing the Medicaid program is impressive and has addressed many problem areas. It indeed needs to be improved. However, I have concerns about how this will affect speech and language services. As a speech language pathologist, who primarily works with the pediatric population, I serve many Medicaid children. I am here for this vulnerable, silent, often forgotten segment of our population. I want to address this issue so that in your preparation for this change, you can adequately provide for this most critical need , so that NO Child is left behind.

"Venders will be allowed to define the amount and scope of benefits," This frightens me for the children. I know that the HMO's and all insurance companies are bottom line driven. With limited or no government guidelines established by Medicaid, these children will be the losers and the venders will be the winners. I site as an example the recent Amerigroup fiasco. Starting in 11/03 AG denied all children's speech and language services, stating that it was not medically necessary. Medicaid at that time and at the present time has very specific guidelines for these services. AG was out of compliance but because of the established parameters, with legal intervention they were forced into compliance and now the children are getting the services that they so desperately need and to which they have a right. With the proposal that venders be allowed to define all benefits, with the existence of no guidelines, there would be no possibility to legally intervene and therefore there would be no therapies for the children. I mention this, as I know that this will be the scenario if the venders can define the amount and scope of these benefits.

When the state devised the Healthy kids program I believe that it was also bottom line driven. The speech services that were allowed, were for only 24 lifetime visits which is useless,. The average length of therapy is approximately 2 years.

All commercial insurance companies have limitations of benefits, duration and defined scope of services. By eliminating guidelines and allowing the insurance companies to determine the scope and duration of therapies, the umbrella under which these children are now protected, will be gone and they will be denied one very critical opportunity to reach their full potential. Speech and language is the foundation and building blocks for

all learning, - not just in the classroom, but all of life's lessons. With poor language skills children are at risk for failure. By virtue of their economic status and life situation these children are at extreme risk. This coupled with speech and language disorders, makes these children destined to frustration in the classroom, quitting school, poor job opportunities and a possible entrance into the penal system. Statistics show that there is a very high incidence of language disorders in the prison population.

Insurance companies have arbitrary time limits for speech and language service which are often greatly underestimated . 2 years for the pediatric population is the average time required, however some children's needs would demand a longer duration. The insurance companies will site that the child can receive the services in the schools. That is true, if the child falls within the school criteria. Even if the child does fit into the parameters, because of poor funding and limited personnel, these children will not get what is required. What they will get is just a band aid. Without the Medicaid benefits for private therapy these children will fall through the cracks. These children must have more time. Perhaps a rating system could be devised to determine the necessary length of time for the services and be determined on an individual basis.

There must be some way to incorporate guidelines for these critical services so that all insurance companies that will be venders for these children will be forced to cover these therapies.

I would be very happy to discuss my thoughts on this subject with you.

Thank you for your time.

Attorneys & Counselors At Law

February 11, 2005

Senator Lisa Carlton, Chair, Senate Select Committee on Medicaid Reform & Rep. Holly Benson & Rep. Joe Negron, Co-Chairs, House Select Committee on Medicaid Reform 530 Knott Building 404 South Monroe St.
Tallahassee, Fl. 32399-1100

Re: Medicaid Reform

Dear Chairpersons Carlton, Benson & Negron and Members of the House and Senate Select Committees:

I am writing today regarding the proposals currently moving through the Legislature concerning the reform of Florida's Medicaid system. My concerns may be summarized as follows:

1. Provide Effective Monitoring of Private Vendors and Contractors. Under Governor Bush's proposal, private providers will be employed to provide services and make determinations on eligibility for services. This is a crucial and basic function of the State. I strongly urge you to provide careful oversight and monitoring of these private companies. This concern is based in actual experience I have had in representing clients who have already been denied Medicaid services by a private company, Maximus, that the State contracts with to review whether a person's services in a Medicaid care plan are actually necessary. At issue was the definition of the words "total" and "intensive". If my client qualified for "total" care, she would be eligible to continue receiving the services she had been receiving for several years. If, however, she were only eligible for "intensive" care, she would lose these benefits. I was unable to find any place where these crucial terms were defined in writing. I cross-examined the representative of Maximus called by the State to support its denial of services. Under oath, this representative admitted that the definition of "total" care was not spelled out anywhere in statute, rule, regulation, or handbook. She admitted that Maximus had not received any training or instruction from the State on how to implement these requirements in making decisions on behalf of the State. She further admitted that she came to her definition of "total" care, that allowed her to deny the care sought by my client, from her own experience and by talking to the other five or six Maximus employees who conducted these reviews for the State. In essence, she admitted that they were basically making it up as they went along. This is improper and unjust and should not be tolerated. The danger of these types of problems occurring on a much broader scale under

these proposals is tremendous and must be closely monitored by the State. Life and death decisions - acting under delegated authority of the State - cannot and must not be left to the tender mercies of unaccountable employees of private corporations who are driven to maximize profits. In this area, the stakes are very high. If mistakes are made because oversight and monitoring is not sufficient, lives will be lost. That is inexcusable.

- 2. Emphasize Home and Community Based Services. I urge you, in any plan that results from this, to emphasize the provision of home and community based services to persons in the Medicaid system. These services are often the most desired and least expensive. Moving away from institutionalization increases the independence of our citizens with disabilities. We have made tremendous progress in this area in the last several decades. We must not go back to the days of segregation and warehousing of people for the sake of convenience and cost savings.
- 3. Insure That Adequate Funding Is Provided For Transition Training and Counseling. The transition that is being contemplated will fundamentally alter the program. Everyone, in essence, will be starting from scratch. There must be adequate lead time and funding for the training of workers and counseling of recipients of benefits to negotiate the new system. Again, the risks here are enormous literally life and death.
- 4. Insure Ultimate Coverage. Simply put, just because someone may be removed from the State's Medicaid rolls, their health care needs do not go away. They will continue to show up, in much more chronic condition, in our local communities. Any calculation of whether these proposals will actually result in savings must take these costs essentially unfunded mandates into account.
- 5. Insure Accessibility to Information and Technology. I have seen many aspects of reform proposals that seek to make greater use of technology in providing information to the public and in determining eligibility. To the extent that this information and technology must be used by persons with disabilities, it is absolutely essential that it be required to be accessible to persons with disabilities.
- 6. Preserve A Just Society. We all know that the spiraling cost of health care is not the responsibility of our citizens on Medicaid. That responsibility lies elsewhere in the management of our nation's health care system. However, our most vulnerable citizens are being asked to bear the burden. By saying we can't afford to provide these services to our most vulnerable citizens, we are saying that, in the world's greatest, most prosperous country, we cannot afford a just society. We cannot allow this. We, as a people, must preserve a just society for all citizens, regardless of an individual's health or wealth.

Thank you for your consideration of these comments. I may be reached at the address and numbers above should you have any questions or require additional information.

Richard La Belle

Very truly yours.





February 11, 2005

Senator Tom Lee 915 Oakfield Drive, Suite E Brandon, FI 33511

Senator Lee:

Florida's Medicaid program provides more than half a million seniors and persons with disabilities with essential health care services, including prescription drugs and long-term care. Medicaid also delivers critical primary and preventive care to more than one million children in Florida. Currently, those low income Floridians who are pregnant, elderly, with disability, or under age 21, and who meet the program's strict eligibility requirements, are guaranteed basic coverage. Most of the cost of their coverage is paid for by the federal government, and this coverage is available regardless of increased enrollment during economic downturns. In addition to providing care for millions of Floridians, this federal funding is enormously important to the health of Florida's economy.

We are particularly concerned about any proposals which seek to cap federal funding for the Florida Medicaid program. This will inevitably lead to decreased eligibility, limitations on benefits and lengthy waiting lists for the sick and persons with disabilities who need timely health care, including nursing home care. It will also lead to rationing of critically needed care, which means we will be faced with untenable choices over who gets care such as the single working parent with cancer who needs a new \$2000/month chemotherapy treatment or a pregnant woman in danger of giving birth to her baby pre-term, worrying about the potential long-term health effects and costs associated with having a baby too early.

We understand that the Administration is currently negotiating with federal officials for authorization to make major changes to the Florida Medicaid program. We urge you and the Legislature to continue to bring sunshine to these discussions. Specifically, we ask that any major restructuring of the Florida Medicaid program have careful consideration and deliberations. To do otherwise will jeopardize the lives of Florida's most vulnerable residents.

The attached list represents the 122 organizations and nine individuals that have signed on to this letter.

Sincerely,

Anne Sweflick

Florida Legal Services, Inc.

Organizations and individuals signing on:

- AARP Chapter #80 (Charlotte County)
- Advocates Committed To Improving Our Nursinghomes (ACTION)
- American Academy of HIV Medicine
- American Federation of State, County and Municipal Employees, Council 79
- Ann Storck Center, Inc.
- ARC/Florida
- ARC of Alachua County, Inc.
- ARC of Madison -Jefferson Inc.
- Associated Home Health Industries of Florida, Inc.
- Bay Area Medical Association (BAMA)
- Bethesda Lutheran Homes and Services, Inc.
- Carlos A. Costa Immigration & Human Rights Clinic, FIU College of Law
- Carlos Milan
- Care Resource
- Catholic Charities Refugee Resettlement
- · Center for Independent Living of South Florida
- C.H.A.I.N.
- C.H.A.I.N. Daytona Beach / Volusia County
- C.H.A.I.N. East Central Florida
- C.H.A.I.N. West-Central Florida LINC
- Citrus Chapter of the National Kidney Foundation
- Civic Concern
- Coalition to Protect America's Elders
- Community Health Advocacy Partnership, Inc. (CHAP)
- Community Voices Miami at the Collins Center for Public Policy
- Coordinating Council of Broward
- Council on Aging of West Florida, Inc.
- Depressive Bipolar Support Alliance, Merritt Island, FL
- Dorothee Custer, R.N.
- Easter Seals Volusia & Flagler Counties
- Florida Academy of Family Physicians
- Florida Alliance for Retired Americans (FLARA)
- Florida Association of Aging Services Providers
- Florida Association of Centers for Independent Living
- Florida Association Directors of Nursing Administration
- Florida Association of Healthy Start Coalitions, Inc.
- Florida Association of Homes for the Aging
- Florida Association of Rehabilitation Facilities
- Florida Chapter of the American Academy of Pediatrics
- Florida Coalition for the Homeless
- Florida Council on Aging, Inc.
- Florida Council for Community Mental Health
- Florida Health Care Social Workers Association

- Florida Impact
- Florida Independent Living Council, Inc.
- Florida Legal Services, Inc.
- Florida Medical Directors Association
- Florida National Council of Jewish Women Public Affairs
- Florida National Council of Jewish Women Kendall Section, Inc.
- Florida Nurses Association
- Florida Pulmonary Society, Inc.
- Florida State Medical Association (FSMA)
- Florida Supportive Housing Coalition
- Florida Transplant Survivors Coalition, Inc.
- Goodwill Industries-Suncoast, Inc.
- Gulfcoast Legal Services, Inc.
- Healthy Start of Flagler and Volusia Counties
- Hearing and Speech Center of Florida
- HIV Medicine Association
- Human Development Center, Inc. Human Services Coalition
- Jacksonville Area Legal Aid, Inc.
- Key Pine Village
- Legal Aid Service of Broward County, Inc.
- Legal Aid Society of the Orange County Bar Association
- Lorella Green, LCSW
- Lupus Foundation of America, Inc., Greater Florida Chapter
- MacDonald Training Center
- March of Dimes Florida Chapter
- Mary Figg Consulting
- MedicaidAdvocates.Com
- Mental Health Association of Central Florida, Inc.
- Mental Health Association of Palm Beach County
- MIA Consulting
- Miami-Dade County Public Schools, Civil Rights and Diversity Compliance
- Micro-Business USA
- Mike VanWagoner
- National Alliance of the Mentally III (NAMI) Florida
- National Alliance of the Mentally III (NAMI) Miami/Dade
- National Alliance of the Mentally III (NAMI) of Palm Beach County
- National Kidney Foundation of Florida
- National Medical Association, Region III
- National Mental Health Associations of Florida, Inc.
- Olderadultaffairs.com
- Orange County Health Department
- Orange County Healthy Start Coalition
- Palm Beach Habilitation Center

- Dr. Patrice Woeppel
 People=s Advocacy Center for Training
- Pinellas Association for Retarded Children (PARC)
- Planned Parenthood of Greater Orlando, Inc.
- Polk County Association for Handicapped Citizens
- Risk Management Services
- Robert M. Levy & Associates
- SAFE AGING
- Sally Coupal
- Service Employees International Union (SEIU) Local 11, Miami Beach
- Service Employees International Union (SEIU) 1199 Florida
- Service Employees International Union (SEIU) Local 1991
- Sharon L. Rice
- Society for Social Work Leaders in Health Care
- South Florida Mental Health Association, Inc.
- Sunrise ARC, Inc.
- Sunrise Community, Inc.
- Tampa Bay Healthcare Collaborative
- Tampa Black Nurses Association
- The AIDS Institute
- The ARC Nature Coast, Inc.
- The Arc of Bradford County
- The ARC of Jacksonville
- The ARC of Palm Beach County
- The ARC of Putnam County
- The Lawton and Rhea Chiles Center for Healthy Mothers and Babies
- The River Fund
- United Cerebral Palsy (UCP) of Central Florida
- United Spinal Association
- United Way of Florida
- Victory Living Programs, Inc.
- VOICES, Inc.
- Walter F. Lambert, MD
- West Broward Family Empowerment Center, Inc.
- West Central Florida Area Agency on Aging Advisory Council
- Women's Emergency Network, Inc.
- WORC Inc/UCP of East Central Florida

INDIVIDUALS:

- 1. Alric Tirado, Interested Citizen
- 2. Barbara Messick, MPH, Coordindator, Ryan White Title IV Program, University of Miami School of Medicine, Department of Obstetrics & Gynecology (D-53)
- 3. Bernard Perlmutter, Director, Children & Youth Law Clinic, Clinical Instructor, University of Miami School of Law

- Karen Woodall, Healthcare Advocate 4.
- Maria Karalus, Interested Citizen 5.
- 6.
- 7.
- 8.
- Mikele Aboitz-Earle, Community Voices, Miami
 Paul C Hunt, March of Dimes, Miami
 Richard Sayette, Concerned citizen, Miami
 Troy E. Elder, Esq., Clinical Fellow, Community Health Rights Education Project,
 University of Miami School of Law 9.





BON SECOURS - ST. PETERSBURG

Dear Legislators:

My name is Luanne Reese and I am here representing Bon Secours Maria Manor a five star facility nationally recognized by JCAHO for our clinical quality programs. I am also a board member of the Florida Association of Homes for the Aging and our facility is a Florida Health Care member as well.

I want to thank you all for taking your valuable time to come to Tampa to hear from the provider community and Medicaid recipients about how changes in the programs will effect all of us.

There are a few keys points that I would like to touch on:

- 1. We know the Medicaid system has to change. We as providers acknowledge that and want to be part of the change.
- 2. While changes need to happen they need to happen in a concise well thought out manner that will create positive change and that keep the system financial viable to serve Florida's most vulnerable people. We applaud the Legislature for taking a step back and slowing the speeding train that was heading toward the provider community.
- 3. Speaking on behalf of one of two Catholic sponsored organizations in the Tampa Bay Area, whatever system Medicaid changes to, choice for the residents must be a key consideration. Residents must be able to choose for reasons of religious preference, proximity to family or ethnicity the place that they would like to call home. After all, don't we all get to select and choose the place that we call home?
- 4. Finally, I would like to talk about reimbursement. I will state this very simply and clearly. If it were not for the fact that Bon Secours Maria Manor is part of a large health care system and the Sisters of Bon Secours support us in living out their mission to providing good help to those in need, our doors would have closed over 2 year ago. The current pressures against us include losing \$10-\$20 a day per Medicaid resident in the facility, which is substantial when you consider 66% of our population, is Medicaid. Our total losses total over \$700,000 dollars this year alone. We are still being punished for doing the right and just thing by carrying liability insurance that is fair and adequate. The community, our families, our staff, our legislators, our governor, our residents and most of all ourselves will only provide care if it is of the highest quality and can be delivered with dignity, compassion and respect for the residents we serve.

In order to survive, mission driven faith-based providers must receive reimbursement that covers the cost of doing business. If the \$200 million in nursing home cuts proposed by Governor Bush are coupled with Medicaid reform, Bon Secours will have difficulty recruiting and retaining qualified nursing home staff and making ends meet.

Our Medicaid system is broken. It is a system that is consistently not paying adequately for service being delivered, a system that is not paying for basic services for the elderly such as dental care. It is a system, if kept the same way, will cause many quality providers to simply say, no more.

I would offer the following as recommendations to include in any proposal to change the system:

- 1. Follow the federal guidelines and suggestions to close loopholes that people use to impoverish themselves financially to qualify for Medicaid eligibility
- 2. Investigate cost savings in the purchasing and utilization of prescription and non-prescription drugs and the regulation surrounding their use for those in nursing homes
- 3. Investigate effect care and case management systems to identify people's health care needs, making the system a proactive rather than reactive one.
- 4. Consider building on the current continuum of care rather than moving completely to a privatized managed care system. The current system can be improved, but is not broken. Florida has one of the lowest nursing bed ratios to elderly population of any state in the nation. We also do a pretty good job of controlling nursing home costs through reimbursement caps and ceilings that are not always fair and through Medicaid waiver projects.

Thank you in advance for your hard work on this issue and the provider community stands ready to help change this important system.

Sincerely,

Luanne Reese Director of Marketing and Planning Bon Secours St. Petersburg FAHA Board of Directors

MEDICAID REFORM

JOINT SENATE AND HOUSE REGIONAL PUBLIC HEARING

February 11, 2005

Marshall Seiden Chief Executive Officer Menorah Manor St. Petersburg, Florida

Good afternoon. My name is Marshall Seiden. I am the Chief Executive Officer of Menorah Manor. We are located in St. Petersburg but my constituency is the Jewish community in six counties of the Tampa Bay region. I represent their intense concern for taking good care of all the elderly who need help. People who have brought their mothers and fathers to Menorah Manor include lawyers, physicians, nurses, state prosecutors, state ombudsmen, elected office holders like yourselves, medical and nursing school faculty and others from a very broad range of the Florida socio-economic spectrum. We are a proud member of the not-for-profit, community and religious sponsored community of elder care providers, represented by the Florida Association of Homes for the Aging. FAHA represents over 300 quality long term care and affordable housing organizations with nearly 80,000 clients and their families.

We, like you, are concerned with the well being of all the important needy populations supported by the government. We agree that the State has many responsibilities and we want to help you keep Medicaid cost reasonable. I should add that 70% of the residents at our 180 bed skilled nursing facility are supported by Medicaid and our Adult Day Health Center is also in the Medicaid Program. We are planning a second campus in north Pinellas County at which our second assisted living facility will also be participating in the Medicaid Program. Menorah Manor's mission, as yours, is to operate a coordinated system of elder care that provides the best possible, appropriate care at the time and place needed by the frail elderly.

The issue you face is the broad problem of the <u>cost</u> of Medicaid. I encourage you to explore <u>all</u> options for controlling Medicaid costs but please remember that you have an ethical and social responsibility to provide good care for the frail elderly of Florida, our parents. Whatever Medicaid looks like in the future please remember that it was created in the 1960's to provide care to the medically indigent, those who have no other means of obtaining health care. It's purpose is to reimburse providers for their cost of providing this care to those supported by the Medicaid Program. It is not long term care insurance.

Managed care is not the only answer but if it is employed it must have several features to protect Florida's system of geriatric care. When you entrust care into the hands of managed care organizations you give up virtually all program controls and if recent

articles on HMO cost increases is any indication, you may end up with a more costly and less controllable system than what we have now. I hope you try to deal with the issues. This includes <u>consumer choice and access</u> to health care providers, <u>quality of service</u>, and <u>payment adequacy</u>.

Choice involves cultural relevance, location and type and quality of service. Quality of service includes professional performance, compliance with regulations, continuity of care, depth of geriatric expertise and other measures. Payment adequacy is simple: providers must be reimbursed for good care or they can't give good care. Right now the overwhelming majority of Florida's nursing homes are not being reimbursed for the care they provide.

There are other ways that you can save Medicaid funds. For example, Medicaid is probably the single largest purchaser of pharmaceuticals in the world. You have the ability to dramatically cut your Medicaid expense by aggressive negotiation with the drug companies.

Another example: Originally for "medically indigent", Medicaid is now used routinely by middle and upper income families to avoid spending their own money on elder care. You have the power to reduce false impoverishment, the divestiture of assets to make a person eligible for Medicaid support. This will also dramatically cut your Medicaid cost.

Right now Medicaid rules prohibit families from supplementing the payments. If you change that Medicaid residents would have better access to care in high facilities without costing Medicaid any additional dollars. The payments can be capped to avoid abuses.

You can close poor performing nursing homes and continue the moratorium on new beds. Fewer beds means higher average occupancy which means greater efficiency in spending Medicaid dollars.

You need an intelligent, enlightened and effective means of providing the elderly the most appropriate care. You should build an effective system of care, a continuum of care that gets people the right services in the best setting.

In closing I want to call you attention to what your constituents do to assure good geriatric care: they donate dollars to organizations like ours. Charity is now being pushed to its limits to compensate...if not for a generous community we would have been at serious risk of either providing inferior care or going out of business. The State cannot push more of the burden of the medically indigent onto the overburdened charitable community. They can't do any more.

Thank you very much for the opportunity to address this matter. Please let us work with you to protect the elderly.



I am 61 years old. I have worked, raised my family and made my contribution to my community through the writing and activism I have done. I am totally disabled due to what is called "environmental illness." I guess you could say I am the canary in the coal mine. Because of exposure to environmental toxins, my body is so damaged that I am unable to go out of my house and can breathe only with supplemental oxygen. I have to live in a climate controlled, dust, mold and toxin free environment and take several medications. In spite of these limitations, I continue my work as an activist and writer on the internet as best I can.

I receive \$579/month from SSI. That is my total income. The medications I am on and the oxygen I need would cost twice that if I had to pay for them. I receive no housing or any other kind of assistance. I was receiving \$75 in food stamps until my SSI check was increased from \$564 to \$579. Now I receive \$69 in food stamps. I am only able to survive because an elderly lady rents me a room in her house.

I do not see how on earth my assistance could be decreased. There are many like me, many in worse circumstances. Our access to medical care is minimal and inadequate. I have heard nothing in all the talk about what to do about the "burden" of Medicaid about the profits that pharmaceutical companies make, the fees charged by doctors, insurance companies and the big corporations who "manage" and profit from the illness and misfortune of the rest of us. While some of us on the lower end of the economic scale suffer, the ones on the high end reap the profits. While we try live on \$69 worth of groceries a month - they think nothing of spending that for one dinner out!

This is a disgrace! People in other countries think we are idiots for putting up with this kind of abuse. There is universal medical care - of good quality - in every "developed" country in the world. This is not a radical concept. Corporate greed is held in check by fairness and justice just about everywhere except here. Corporate profit is the place to cut. Not the slender lifelines of the most vulnerable, most oppressed members of this society.

Rebecca Swan Bradenton FL

Page, Barb

From:

Howells, Steve

Sent:

Friday, February 11, 2005 10:38 AM

To:

>>PAIR/TAP

Subject: RE: Medicaid Reform Comments:

As you partner to help protect Florida's most vulnerable children and adults with disabilities, elders with disabilities, and the working poor, here is some additional information:

- 1. I am attaching a paper from Georgetown university you should consider in your presentation. The huge error in setting the framework for Medicaid reform, the percentage of the Medicaid state budget is figured incorrectly and we need to get this fact out.
- 2. The Centers for Medicare & Medicaid Services has recently withdrawn a notice seeking proposals from private, for-profit entities for a Medicare-Medicaid demonstration project to study the provision of comprehensive, coordinated care to the frail elderly through a prepaid, capitated system. *No proposals were submitted*. Notice, 69 Fed. Reg. 68931 (Nov. 26, 2004).
- 3. Services that maybe labeled "optional" in Medicaid reform are essential to keeping people in the community and out of costly institutional settings. <u>Esteban v. Cook</u> and <u>Hunter v. Chiles</u> are base line acknowledgements of the crucial role of Medicaid for people with disabilities and should be protected.
- 4. Here are some alternatives to the massive overhaul of Medicaid being proposed to consider: *Making Medicaid Work* report from the National Academy for State Health Policy. I'm attaching the recommendations. You can access the full report at the National Academy website, whose address is given on the recommendation sheet that is attached.

In addition, we should call on the state to:

- (a) Use accurate data so that the true nature of the problem is known by all.
- (b) Reform drug purchasing (see attached summary of recent office of inspector general recommendations that would save billions)
- (c) Use bulk purchasing among all state programs, e.g. workers' comp and Medicaid, thus harnessing the purchasing power of the state to buy drugs, equipment, and other devices.
- (d) Use Correct Coding Initiative automated edits to evaluate claim submissions when a provider bills more than one service for the same beneficiary and same date of service. Medicare uses this and, if used by the state, could save millions (see attached);
- (e) Emphasize home and community based services for people currently in institutional settings. Research shows community-based settings to be less costly than institutional care.

I hope this helps.

Steve Howells, PAIR/TAP Director and Interim Administrative Services Director Advocacy Center for Persons with Disabilities, Inc. 2671 Executive Center Circle, West, Suite 100 Tallahassee, Florida 32301 1-800-342-0823, ext. 211 850-488-9071, ext. 211 850-488-8640 - fax

From: Howells, Steve

1 450 2 01 0

Sent: Wednesday, February 09, 2005 4:01 PM

To: >>PAIR/TAP

Subject: Medicaid Reform Comments:

Steve Howells, PAIR/TAP Director and Interim Administrative Services Director Advocacy Center for Persons with Disabilities, Inc.

2671 Executive Center Circle, West, Suite 100

Tallahassee, Florida 32301

1-800-342-0823, ext. 211

850-488-9071, ext. 211

850-488-8640 - fax

> FOR IMMEDIATE RELEASE CONTACT: Kathy Mears (850) 487-5632 or Towson Fraser (850) 488-1450 > January 27, 2005 > > Senate President Tom Lee and House Speaker Allan Bense Announce Joint > Regional Public Hearings on Medicaid Reform > Tallahassee, Fla. - In preparation for upcoming legislative action on > Medicaid, the Senate and House today announced their intention to > conduct joint public hearings on Medicaid Reform. These regional > hearings will take place throughout Florida beginning Friday, February > 11 and concluding on Monday, March 14. > > The purpose of the hearings is to gather information from providers > and Medicaid recipients who may be affected by changes to Florida's > Medicaid program and to collect innovative ideas on ways to reduce the > rapid growth in Medicaid costs while continuing to provide needed > services to Florida's elderly and disabled. The Committees will also

```
> solicit input on the Governor's proposal to reform Medicaid.
 > Today's information follows recent announcements by the Senate
 > President and the House Speaker of the formation of a Senate Select
 > Committee on Medicaid Reform and a House Select Committee on Medicaid
 > Reform. These committees have been charged with the responsibility of
 > gathering information and making recommendations to their respective
 > chambers for changes to the state's Medicaid program. Attached is a list of the
 > membership of the two select committees.
 > The dates and regional location of each public hearing are listed
 > below, but are subject to change. Please refer to the published
> calendars for the House and Senate which will reflect the most
> up-to-date information, which can be accessed on the legislative
> websites: www.flsenate.gov or www.myfloridahouse.gov.
> Members of the Senate Select Committee on Medicaid Reform
> Sen. Lisa Carlton (R- Sarasota), Chair
> Sen. Jeffery Atwater (R- Palm Beach), Vice Chair
> Sen. Burt Saunders (R- Naples)
> Sen. Durell Peaden (R- Crestview)
> Sen. Mike Haridopolos (R- Melbourne)
> Sen. Alex Villalobos (R- Miami)
> Sen. Walter Campbell (D- Ft. Lauderdale)
> Sen. Mandy Dawson (D-Ft. Lauderdale)
> Sen. Ron Klein (D-Boca Raton)
```

```
> Members on the House Select Committee on Medicaid Reform
> Rep. Joe Negron (R -Stuart), Co-Chair
> Rep. Holly Benson (R -Pensacola), Co-Chair
> Rep. Joyce Cusack (D-DeLand)
> Rep. Anne Gannon (D- Delray Beach)
> Rep. Andy Gardiner (R -Orlando)
> Rep. Mark Mahon (R - Jacksonville)
> Rep. Marco Rubio (R - West Miami)
> Rep. Aaron Bean (R - Fernandina Beach)
> Rep. Eleanor Sobel (D- Hollywood)
> Proposed Joint Hearing Schedule
> -----
> Date: Friday, February 11, 2005
> Time: 1:00 p.m. - 4:00 p.m.
> Location: University of South Florida, Gibbons Alumni Center, Tampa
> Date: Monday, February 14, 2005
> Time: 1:00 p.m. - 4:00 p.m.
> Location: Ft. Lauderdale, (exact location, TBA)
> Date: Monday, February 21, 2005
> Time: 1:00 p.m. - 4:00 p.m.
> Location: Orlando, (exact location, TBA)
```

1460 1010

```
> Date: Friday, February 25, 2005
> Time: 1:00 p.m. - 4:00 p.m.
> Location: Panama City, (exact location, TBA)
>
> Date: Monday, March 14, 2005
> Time: 1:00 p.m. - 4:00 p.m.
> Location Jacksonville, (exact location, TBA)
```

Steve Howells, PAIR/TAP Director and Interim Administrative Services Director Advocacy Center for Persons with Disabilities, Inc.
2671 Executive Center Circle, West, Suite 100
Tallahassee, Florida 32301
1-800-342-0823, ext. 211 850-488-9071, ext. 211 850-488-8640 - fax

Saving Medicaid Money Without Cutting Coverage

Addressing Prescription Drug Overpricing

Late last year, Assistant Inspector General for the Centers for Medicare & Medicaid Services (CMS) George M Reeb testified before a House Subcommittee that "the Medicaid program continues to pay too much for prescription drugs." According to the OIG, Medicaid is losing millions of dollars annually because of prescription drug overpricing. Inspector Reeb identified a number of areas where the Office of Inspector General (OIG) has concluded that state Medicaid programs are paying too much. Three of them are summarized below:

• Pharmacy acquisition costs verses state Medicaid average wholesale prices

The OIG has found that the average wholesale prices (AWPs) that states use to establish their Medicaid drug reimbursements generally bear little resemblance to the prices retail pharmacies pay for the same drugs.

The OIG estimated that pharmacy acquisition costs for brand name drugs in 1999 were an average of 21.8 percent below state Medicaid programs' AWPs and for generic drugs were an average of 65.9 percent below the AWPs. This comparison of pharmacy acquisition costs to states' AWPs did not account for additional discounts that drug manufacturers and wholesale distributors make available to most pharmacies' acquisition costs, such as volume and prompt pay discounts.

The OIG suggests that state Medicaid programs consider developing a payment methodology that uses actual pharmacy invoice prices.

• The Federal Upper Payment Limit

The OIG has repeatedly found that CMS is not promptly adding qualified, multiple-source generic drugs to the Federal Upper Payment List (FUPL). Federal law requires CMS to include a drug on the FUPL if at least three versions of the drug are rated as therapeutically equivalent by the Food and Drug Administration and the drug has at least three suppliers listed in the current editions of national compendia. CMS publishes the list of FUPLs on its web site, www.cms.gov/medicaid/drugs/drug10.asp. States will typically reimburse for a drug at the FUPL if that is the lowest price when compared to other pricing mechanisms, such as the acquisition cost or providers' usual and customary charge.

A December 2004 review by the OIG found that, of the 252 first-time generic drugs approved between January 2001 and December 2003, 109 drugs met the legal criteria for inclusion on the FUPL. However, only 25 were listed by July 15, 2004. For the 25 that were added, CMS took an average of 36 weeks to place the products on the list once the drugs were qualified for inclusion. As of July 15, 2004, the 84 drugs that

had not been added had been qualified for the FUPL for an average of 55 weeks. Twenty-nine of these drugs had been qualified for at least 80 weeks. The delays and failures to add the qualified drugs cost state and federal Medicaid programs an estimated \$167 million, of which 85 percent (\$143 million) of the losses were attributable to delays in adding just eight of these drugs. For example, the two-quarter time lag in adding the 20mg dosage size of Fluoxetine capsules (brand name Prozac) cost Medicaid an estimated \$57 million. OIG, Addition of Qualified Drugs to the Medicaid Federal Upper Limit List (Dec. 2004). A February 2004 review by OIG reached similar conclusions, finding that 90 drug products were not included on the FUPL in 2001 despite meeting the federal criteria. Medicaid could have saved \$123 million in 2001 by adding 55 of the 90 drug products to the list. OIG, Omission of Drugs from the Federal Upper Limit List in 2001 (Feb. 2004).

OIG has recommended that CMS establish an administrative process and schedule to govern the determination and publication of the FUPL. It points out that over the next several months, new generic versions of several brand name drugs may become qualified for the FUPL. Three of these drugs—Gabapentin (brand name Neurontin), Oxycodone Hydrochloride (brand name Oxycontin), and Paroxetine Hydrochloride (brand name Paxil)—accounted for a total of \$5.3 billion in retail sales in 2003.

State variations in reimbursements for the same drugs

States have discretion in setting their payments for prescription drugs. An OIG study assessed the extent to which states vary in their Medicaid reimbursement for 28 randomly selected drugs (from among 600 drugs codes for which there were substantial Medicaid outlays).

Based on data from 42 states, the OIG estimated that, overall, Medicaid could have saved as much as \$86.7 million in fiscal year 2001 if all 42 states had reimbursed at the same price as the lowest payment state for each of the 28 drugs reviewed. In fact, Medicaid could have cut its spending by more than half if all states had paid the same price as the lowest paying state for only nine of the 28 drugs.

The OIG recommends that CMS publish comparative information for state Medicaid programs about states' payments for prescription drugs and share price data that would allow states to engage in more cost effective drug pricing.

Implementing Correct Coding Initiative Edits

Another cost saving mechanism involves the Correct Coding Initiative (CCI). The OIG has explored the use of Medicare Correct Coding Initiative (CCI) edits within state Medicaid programs. CCI consists of automated edits used to evaluate Medicare claim submissions when a provider bills more than one service for the same beneficiary and same date of service. The coding is based on general correct coding principles, and the codes are available for download from the CMS website.

The use of CCI edits is mandatory in the Medicare program, but state Medicaid agencies are not required to use these edits when processing claims. Only seven states use some or all of the coding edits:

AZ: uses all edits except for anesthesia GA: uses all edits MT: uses edits related to surgical codes NC: uses all edits ND: uses all edits WA: uses 16 edits

WV: uses edits related to surgical codes

A review of claims data for 39 states by the OIG found that these states paid \$54 million for services that would have been denied based on CCI edits. Nearly half of the \$54 million in payments for services the CCI edits would have denied were made for coding in the medicine category, which includes psychiatry, physical therapy, cardiovascular, and pulmonary services.

The OIG recommends that states made use of use or all of the CCI edits. CMS plans to distribute copies of the OIG report to the states. OIG Report, *Applying CCI Edits to Medicaid Services* (Oct. 2004).

These, and other reports, are available from the OIG web site: http://oig.hhs.gov





Health Policy Institute

Policy Brief

Medicaid Cost Pressures for States: Looking at the Facts

Cindy Mann and Fouad Pervez

Medicaid is now the largest single source of health care coverage in the nation. Most of its 53 million enrollees are children, but the lion's share of the costs are for people with significant health and long term care needs -- the elderly and people with disabilities. Nearly half of all nursing home care in the country is financed by Medicaid.

Medicaid is a large program and, particularly in the past several years, costs have been growing, although on a per person basis more slowly than in the private sector. The increase in costs is largely a reflection of three factors: generally rising health care costs, the recent downturn in the economy which caused more people to need and qualify for Medicaid, and Medicaid's growing responsibility filling in the gaps in Medicare. (See box on page 6.) Rising Medicaid costs have created considerable stress for states, which finance an average of 43 percent of program spending. The stress on state budgets is real, but some of the characterizations of Medicaid as the "budget monster" or "Pac man" have obscured or mischaracterized important points about Medicaid's role and can lead to ill-advised policies. For example, based in part on a misleading analysis of Medicaid spending in Florida, Governor Jeb Bush has proposed a radical plan that would convert the program into capped individual budgets and let private plans determine Medicaid benefit guarantees and cost sharing.²

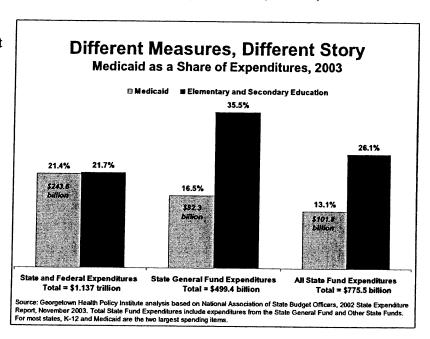
Medicaid's role in state budgets is considerably more complicated than the headlines suggest. This brief provides data on how much each state spends on Medicaid and considers the ways in which Medicaid provides considerable fiscal relief to states and local communities.

2233 Wisconsin Avenue, NW Suite 525 Washington DC 20007 202-687-0880 202-687-3110 facsimile http://hpi.georgetown.edu

Measuring the Squeeze: Different Numbers, Different Story

Data collected by the National Association of State Budget Officers (NASBO) show how

states spend their funds and provide insight into the different ways that Medicaid affects state budgets. The number that has captured attention is that in fiscal year 2003 Medicaid consumed 21.4 percent of state budgets, a close second to K-12 education (21.7 percent).³ This number has been cited widely in newspaper articles, as well as by some policymakers calling for sweeping Medicaid reform.



These numbers can be informative or misleading, depending on the context in which they are used. They reflect Medicaid's share of *total* expenditures—including spending that is financed with *federal* dollars. When the question is, "How does Medicaid spending affect states' ability to finance other state priorities?", it is more appropriate to consider the level and percentage of *state* funds that are spent on Medicaid. This is the approach adopted by the Congressional Research Services in its recent analysis of Medicaid's impact on the state fiscal crisis. Payments that a state receives from the federal government to help finance Medicaid-covered health care do not squeeze out state spending for education, corrections or other state priorities. Federal Medicaid funds must be spent on Medicaid services. Indeed, federal Medicaid funds often relieve state financing pressures by freeing up state and local funds that would otherwise be spent on health care, allowing those freed-up funds to be spent on other programs and services.

The story changes considerably when federal funds are excluded from the calculations. NASBO data divides state funds into two broad categories: "state general funds" and "other state funds." (See text box below for an explanation of these terms.) When state general funds are considered, Medicaid's share of spending drops to 16.1 percent, still considerable, but much less than the 21.4 percent commonly cited. If all state spending is considered (excluding federal funds but considering state general funds and other state funds), Medicaid's share of state spending drops to 13.1 percent. Education also benefits from federal funding but not to the same extent as Medicaid. When federal funds are excluded from the calculation, K-12 education accounts for 35.5 percent of state general fund spending and 26.1 percent of all spending from state sources, accounting for significantly higher levels of state funding than Medicaid. (Figure 1)

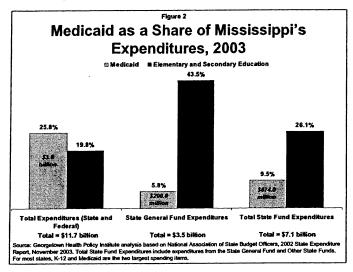
State Funds—Explaining the Terms

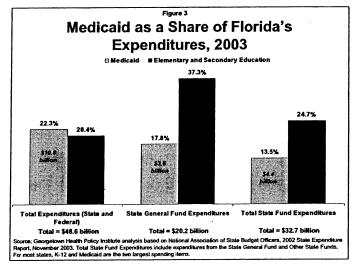
The "General Fund," according to NASBO, is the "predominant fund for financing a state's operations." It is where broad-based state taxes (e.g., income and sales taxes) are deposited. By contrast, "Other State Funds" receive funds from restricted revenue sources, such as gas taxes earmarked for highway construction and funds received from the tobacco settlement used for health care and public health initiatives.

All states rely on the state general fund to finance Medicaid, but some use special fund dollars as well. Nationwide, 7.1 percent of "other state funds" were used for Medicaid in 2003, but the pattern varies widely. Nine states spent no "other state funds" on Medicaid in 2003. The sources for each state's spending should be examined to determine whether it is more appropriate for that state to look only at state general funds or at all state sources of funds. In some states, if only general fund spending is considered, a significant amount of other state funds spent on Medicaid might be overlooked. That could understate Medicaid's impact on state finances. However, in states that do not spend much or any of their "other state funds" on Medicaid, counting these fund sources might skew the analysis in the other direction by considering sources (like gas tax revenues) which may be earmarked for specific purposes.

Different States, Different Story

The figures discussed above are for the nation as a whole. The different measures will produce even more dramatically different results in some states, particularly those with higher-than-average federal Medicaid matching rates. For example, in Mississippi, Medicaid accounts for 25.8 percent of total spending (federal funds, state general funds and other state funds), but



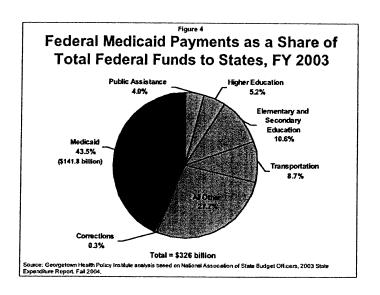


when federal funds are excluded, Medicaid's share of state spending drops to 5.8 percent (considering state general funds only) or 9.5 percent (considering state general funds and other state funds). (Figure 2)

In Florida, Governor Bush has described Medicaid's impact on state finances by looking at total spending (state and federal). In 2003, Medicaid accounted for 22.3 percent of Florida's total spending, but well over half (59%) was financed with federal Medicaid funds. When only Florida state funds are considered, Medicaid accounted for 17.8 percent of Florida's general fund spending and 13.5 percent of all state funds. (Figure 3) See Table 1, page 8, for data for all 50 states.

The Value of Federal Funds

Rather than being a drain on state budgets, the federal Medicaid funds spent by each state make a significant contribution to that state's ability to provide its residents access to health care. In 2003, federal Medicaid payments to states totaled \$141.8 billion; Medicaid was the single largest source of federal grants to states. (Figure 4)



In addition to helping states provide coverage and long term care services to their residents, federal Medicaid funds provide direct and indirect help to states in a number of ways:

- Federal Medicaid funds directly support priorities often cited as competing with Medicaid. For example, Medicaid strengthens and supports education opportunities for children by funding the health care components of early intervention services, Head Start and special education. Medicaid also helps finance child welfare services and an array of public health initiatives in many states.
- Federal Medicaid payments indirectly help states finance other priorities by freeing up state dollars that otherwise would have been spent on health care. One reason why Medicaid has grown is that over the years most states have (appropriately) covered services that had been financed with state or local dollars through Medicaid in order to leverage federal funding. For example, a range of community mental health services that are financed through Medicaid would likely be provided with state or local dollars if federal Medicaid funds were not available. The state (and local) funds not spent on health care thanks to Medicaid are potentially available for other priorities.

Federal Medicaid funding flows to local communities and contributes to local
economies by creating jobs, financing the purchase of medical supplies and other
goods and services, and thereby generating additional state and local tax revenues.
All of the studies that have estimated the effect of federal Medicaid payments on
state and local economies have found a strong, positive impact.⁶

Why Are Medicaid Costs Growing?

After a period of relatively slow growth, Medicaid spending has been rising in recent years. Several factors explain these trends:

- The cost of health care has been rising in both private and public sectors, with prescription drug costs skyrocketing at an average annual rate of 15.5 percent from 1998 to 2003. Medicaid prescription costs grew at an average annual rate of 19.3 % between 1998 and 2003.
- While health costs have been growing in both the private and public sectors, on a per person basis, Medicaid costs are lower than private insurance. An Urban Institute study showed that Medicaid costs 30 percent less for adults and 10 percent less for children than private insurance. Medicaid costs have also been growing considerably more slowly than private insurance. Between 2000 and 2003, acute care Medicaid costs per enrollee grew by 6.9 percent, compared to private insurance premium increases of 11 to 13 percent.
- Over the past few years, enrollment gains have contributed to higher costs. Medicaid is designed to be countercyclical—when other sources of coverage contract, Medicaid expands. For children, the decline in employer-based coverage during the downturn was more than offset by the growth in publicly-funded coverage. Thus, the number and percent of uninsured children actually dropped as a result of gains in Medicaid and the State Children's Health Insurance Program.
- A key driver and source of concern for state Medicaid programs is the rising cost of covering so-called "dual eligibles"—Medicare beneficiaries who rely on Medicaid for supplemental coverage and help with cost sharing. Medicaid—not Medicare—is primarily responsible for providing long term care for Medicare beneficiaries. The cost shift from Medicare to Medicaid is substantial (nationwide, about 42% of all Medicaid expenditures were for dual eligibles in 2002) and will grow over time as the baby boomers retire.

Sources: National Health Care Expenditures from Centers on Medicare and Medicaid Services. Data available online: http://www.cms.hhs.gov/statistics/nhe/historical/nhe03.zip. Hadley J, Holahan J. "Is Health Care Spending Higher under Medicaid or Private Insurance?" *Inquiry*, Vol. 40, No. 4, Winter 2003/2004. *Inquiry* 2004. Holahan J, Bruen B, Urban Institute. "Medicaid Spending: What Factors Contributed to the Growth between 2000 and 2003?" Kaiser Commission on Medicaid and the Uninsured, September, 2003. Strunk BC, Reschovksy JD. "Trends in US Health Insurance Coverage, 2001-2003." Center for Studying Health System Change, August 2004. Cohen RA, et. al. "Health Insurance Coverage: Estimates from the National Health Interview Survey, January-September 2003." Centers for Disease Control and Prevention, March 2004.

Conclusion

Medicaid is at a crossroads. Changes are needed to provide states with more resources and tools to deal with rising health care costs, an aging population and the increasing demand for long term care. Misunderstandings and mischaracterizations of Medicaid's impact on state budgets and budget priorities cloud, rather than illuminate, these important issues. Instead of helping to move the public debate toward workable solutions, they may lead to results that are harmful not only to the program's ability to do its job but also to the longer term health of state and local finances.

February 1, 2005

¹ State funds spent on Medicaid are matched by the federal government, with the federal match rate (known as "FMAP") ranging from a minimum of 50 percent up to 77 percent. (Medicaid expenditures for some selected services and supports are matched at a higher rate for all states.) As such, at least half, and in some cases, over three-quarters, of total state Medicaid expenditures are paid for with federal, and not state, dollars. See Table 2 for the federal matching rates for the 50 states and the District of Columbia.

 ² "Florida Medicaid Modernization Proposal," Jeb Bush, Governor, State of Florida, January 11, 2005, page 1.
 ³ National Governors Association, National Association of State Budget Officers, Press Release, *Medicaid Squeezes State Budgets*, October 12, 2004.

⁴ C.Scott, Congressional Research Services, CRS Report for Congress, "Medicaid and the Current State fiscal Crises," Updated February 17, 2004.

⁵ National and state data are from the National Association of State Budget Officers, 2003 State Expenditure Report, Fall, 2004, available at www.nasbo.org. This analysis does not consider local spending which is far more significant for K-12 education than for Medicaid. According to the Department of Education, 37 percent of funding for education comes from local funds. National Association of State Budget Officers, 2003 State Expenditure Report, November 2003, page 14.

⁶ Carbaugh A. "The Role of Medicaid in State Economies: A Look at the Research." Kaiser Commission on Medicaid and the Uninsured, April 2004.

Table 1: Medicaid as a Percent of State Expenditures, FY 2003

		State Medicaid Expenditures	State and Federal Medicaid
	State Medicaid Expenditures	as a Share of State General	Expenditures as a Share of
	as a Share of State General	Fund and Other State Fund	Total State and Federal
State	Fund Expenditures	Expenditures	Expenditures
Alabama	5.3%	10.2%	22.3%
Alaska	8.3%	6.0%	12,1%
Arizona	14.1%	9.0%	20.7%
Arkansas	11.4%	7.3%	19,5%
Califomia	13.6%	12.9%	18.5%
Colorado	18.3%	11.7%	17.8%
Connecticut	22.8%	22.4%	25.3%
Delaware	12.9%	7.4%	11.5%
Florida	17.8%	13.5%	22.3%
Georgia	11.0%	-10,4%	17.6%
Hawaii	8.0%	5.2%	9.7%
ldaho	11.6%	10.1%	19.6%
Illinois	18.9%	18.3%	25.4%
Indiana	14.6%	11.3%	20.5%
Iowa	9.5%	9.8%	18.1%
Kansas	11.8%	8.7%	16.0%
Kentucky	10.4%	9.1%	20.8%
Louisiana	12.2%	10.6%	26.2%
Maine	20.3%	13.5%	28.2%
Maryland	19.1%	11.6%	17.7% 20.8%
Massachusetts	14.0%		
Michigan	18.5%	11.6%	20.0%
Minnesota	17.3% 5.8%	13.3% 9.5%	25.8%
Mississippi Missouri	18.7%	18.7%	32.6%
Montana	9.8%	6.1%	15.6%
Nebraska	17.3%	9.8%	18.9%
Nevada	25.1%	14.4%	20.2%
New Hampshire	25.1%	19.5%	26.4%
New Jersey	15.8%	13.5%	20.6%
New Mexico	11.1%	6.9%	17.8%
New York	15.8%	15.6%	28.4%
North Carolina	14.7%	12.0%	23.4%
North Dakota	12.9%	9.1%	19.0%
Ohio	37.0%	23.8%	23.1%
Oklahoma	12.3%	8.1%	18.4%
Oregon	17.1%	9.6%	18.7%
Pennsylvania	19.4%	19.8%	28.8%
Rhode Island	23.5%	16.6%	26.3%
South Carolina	9.1%	10.1%	22.0%
South Dakota	17.7%	9.1%	14.9%
Tennessee	. 25.2%	19.9%	33.9%
Texas	16.4%	13.2%	23.0%
Utah	5.6%	6.3%	14.5%
Vermont	14.8%	14.2%	25.8%
Virginia	15.8%	8.5%	13.5%
Washington	23.8%	14.4%	22.2%
West Virginia	6.1%	3.4%	11.1%
Wisconsin	13.2%	6.0%	12.6%
Wyoming	9.6%	3.7%	7.9%
ALL STATES	16.5%	13.1%	21.4%

Source: Georgetown Health Policy Institute analysis based on "2003 State Expenditure Report." National Association of State Budget Officers, Fall 2004.

Table 2: Medicaid Federal Match Rate (FMAP), FY 2005

State	Federal Medical Assistance Percentages, FY 2005
Alabama	70.83%
Alaska	57.58%
Arizona	67.45%
Arkansas	74.75%
California	50.00%
Colorado	50.00%
Connecticut	50.00%
Delaware	50.38%
District of Columbia	70.00%
	58.90%
1 IOTAG	60.44%
Georgia	58.47%
Hawaii	70.62%
Idaho	
Illinois	50.00%
Indiana	62.78%
Iowa	63.55%
Kansas	61.01%
Kentucky	69.60%
Louisiana	71.04%
Maine	64.89%
Maryland	50.00%
Massachusetts	50.00%
Michigan	56.71%
Minnesota	50.00%
Mississippi	77.08%
Missouri	61.15%
Montana	71.90%
Nebraska	59.64%
Nevada	55.90%
New Hampshire	50.00%
New Jersey	50.00%
New Mexico	74.30%
New York	50.00%
North Carolina	63.63%
North Dakota	67.49%
Ohio	59,68%
Oklahoma	70.18%
Oregon	61.12%
Pennsylvania	53.84%
Rhode Island	55.38%
South Carolina	69.89%
South Dakota	66.03%
	64.81%
Tennessee	60.87%
Texas	72.14%
Utah	60.11%
vennoni	50.00%
Virginia	
Washington	50.00%
West Virginia	74.65%
Wisconsin	58.32%
Wyoming	57.90%
	57.90% 64.01% 63.76%

Source: Federal Register, December 3, 2003 (Vol. 68, No. 232), pp. 67676-67678. Available online: http://aspe.os.dhhs.gov/health/fmap05.htm.







Overview of Recommendations

In the four decades since its creation, the Medicaid program has grown and evolved in dramatic and often unexpected ways. As the program and its costs continue to grow, policymakers have been motivated to consider how Medicaid might be modernized both to contain costs and enhance services. The National Academy for State Health Policy—with funding from the David and Lucile Packard Foundation, the Robert Wood Johnson Foundation, AARP, and the Agency for Health Care Research and Quality—convened a group of experts with a broad range of experience in the Medicaid program to explore how to make Medicaid work better in the 21st century.

NASHP announces the release of a major new report, drawing upon the work of that group, that identifies numerous opportunities for strengthening the Medicaid program and enabling it to continue to play a critical role in the country's health care system. The report's detailed recommendations identify opportunities for improvement in all areas of the Medicaid program and include calls for simplifying and expanding eligibility, increasing program flexibility for optional populations, improving coordination and integration with the Medicare program and private insurance, adjusting current financing mechanisms, and providing states with tools to manage the long-term care system and, in the process, rebalance the institutional and home and community-based care systems.

The report's recommendations include the following:

Eligibility

- Medicaid should provide comprehensive health care coverage for the poorest Americans—all people with incomes at or below the federal poverty level—without regard to age, family structure, or health status. Current requirements to cover children and pregnant women with incomes above the poverty level should be preserved. Further, states should continue to be permitted to extend Medicaid eligibility beyond minimum federal requirements.
- States should be offered more flexibility in determining eligibility, including the ability to simplify eligibility requirements by basing eligibility just on income.
- States should be given new options for setting financial and functional criteria to qualify for long-term care services. States should be permitted to modify income and assets tests to allow those applicants seeking community care who are most likely to use up their resources within a short time of entering a nursing home to qualify for Medicaid financed acute and community care (but not institutional services) while they are still in the community. States should also be permitted to set different functional criteria for institutional and community long-term care services.

Benefits

- Medicaid should continue to guarantee all mandatory eligibility groups the comprehensive acute, primary care and long-term care benefits defined under current law.
- Medicaid rules should allow states more flexibility in benefit design for persons with incomes above the national minimum eligibility levels. If a state chooses to offer benefits to an optional group, the state would be required to offer acute and preventive care, but could choose whether or not to offer long-term care. For an optional group, a state could choose an acute and preventive benefit package that was the same as that provided to mandatory groups, or a less comprehensive benefit package that meets certain benchmark standards.
- Parents of Medicaid-eligible children should be able to choose to enroll their children in the SCHIP program so long as certain enrollee-protection standards are met.
- States should be allowed to convert their home and community-based waivers into an
 ongoing program within Medicaid, thereby eliminating the cost-neutrality and periodic
 renewal requirements of the existing waiver system.

Financing

- The existing federal-state matching structure should be retained and improved. Federal Medicaid financing should not be converted to a block grant to states.
- The federal government should provide states with an enhanced match (at the SCHIP rate) for the new costs associated with simplifying and expanding eligibility to include all Americans with income at or below the federal poverty level.
- The formula for federal matching funds should be revised to provide a more timely counter-cyclical response to economic downturns.
- The federal government should provide more support to states for the Medicaid costs associated with low-income persons enrolled in Medicare. This increased level of support should be provided in conjunction with efforts to improve care coordination and program management between the two programs.
- States should be given new opportunities to coordinate Medicaid coverage with private, employer-sponsored insurance through "premium assistance" programs. States should be allowed to implement premium assistance programs under a state plan amendment with certain features that now require a waiver, such as policies related to wrap-around benefit coverage, wrap-around cost sharing, and crowd-out prevention. Further, states should be allowed to require employers to enroll their Medicaid-eligible employees in the employer's health plan at times other than the open enrollment period.

This report draws from the experience and expertise of a diverse workgroup. Recommendations made in this report reflect the consensus or majority view of workgroup members but do not necessarily represent the views of project funders or individual workgroup members. The workgroup considered this final product of the MMW project as an inter-related set of recommendations which would best be considered as a whole.

To view or download the full report, visit the Medicaid pages of the NASHP Web site at www.nashp.org.



Advocacy Center for Persons With Disabilities, Inc.

Florida's Protection and Advocacy Programs

Public Comment on Medicaid Reform

Offered by Gordon B. Scott, Protection and Advocacy / Technology Assistance Program (TAP) Senior Attorney and Steven L. Howells, Protection and Advocacy / TAP Director

Advocacy Center for Persons with Disabilities, Inc.

February 9, 2005

We want to thank Senate President Tom Lee and House Speaker Allan Bense for having the foresight to appoint select committee members of the House and Senate to conduct joint public hearings in regions of this State and inviting public comment on proposed Medicaid reform.

As you know, strong grass roots advocacy and a tremendous bipartisan effort led to the creation of the Medicaid Act in 1965. As Congress intended, not only has Medicaid literally saved lives, but has also transformed the lives of individuals with disabilities by enhancing their quality of life helping those individuals to become more independent and enabling them as well as the indigent working poor to become tax paying contributors to our society.

The Medicaid Program was established by Title XIX of the Social Security Act, 42 U.S.C. § 1396, et seq., and is designed to be a cooperative federal-state partnership. It is fitting that all of the public testimony be carefully evaluated and considered by this committee and the appropriate Health Care and other legislative committees before any changes are made that have the potential of negatively impacting the ability of individuals with disabilities to independently live and work in their communities.

We appreciate the gravity and the enormity of the task before you. As you undertake the responsibility of evaluating Medicaid reform proposals, it is crucial that you ensure those proposals do not harm recipients or eliminate basic medical services that are necessary to protect vulnerable elders, individuals with disabilities and families of the working poor. Furthermore, in evaluating reform proposals Florida must be vigilant to ensure that the Congressional intent is upheld. We must ensure that the system is able to continue

☐ 2671 Executive Center Circle West, Suite 100 Tallahassee, FL 32301-5092 tel. 850.488.9071 fax 850.488.8640 toll free 800.342.0823 toll free TDD only 800.346.4127 2901 Stirling Road
Suite 206
Ft. Lauderdale, FL 33312
tel. 954.967.1493
fax 954.967.1496
toll free 800.350.4566
toll free TDD only 866.478.0640

The Times Building
Suite 513 1000 N. Ashley Drive
Tampa, FL 33602
tel. 813.233.2920
fax 813.233.2917
toll free 866.875.1794
toll free TDD only 866.875.1837

providing vital services in the amount, duration, and scope to reasonably achieve the fundamental purpose of Medicaid. It is absolutely essential that any changes to the system first protect elders and individuals with disabilities; ensure a responsible and accountable Medicaid delivery system; and fulfill the legal obligations under the Medicaid Act and federal regulations. It would be irresponsible and shortsighted to do otherwise. Florida must not allow harm by arbitrarily reducing the amount, duration, and scope of Medicaid services to an otherwise eligible individual based solely on the diagnosis, type of illness or condition. Such discrimination violates 42 U.S.C. § 1396 a(a)(10)(B).

The following comments are derived from and are in response to real life circumstances facing thousands of individuals with disabilities, elders, their families, and the indigent working poor who are attempting to understand and navigate an already difficult and complex Medicaid system.

• Hunter v. Chiles

In the mid 1990's, after we worked to exhaust all options and remedies through year-long negotiations with the Agency for Health Care Administration (AHCA), the Protection and Advocacy / Technology Assistance Program (TAP) was left with no alternative but to file a federal class action to protect the rights of children and adults with severe speech disabilities to receive assistive technology (AT), training and support services in the form of augmentative communication devices as medically necessary durable medical equipment. The case resulted in a federal court order that interprets federal law requirements for the provision of medically necessary Medicaid services to those with communication disabilities (see Attachment #1).

We bring this to your attention because any contemplated Medicaid changes must be in consideration of this federal court order, which since October 24, 1996, has enabled adults with disabilities to live more independent lives to become contributing tax paying citizens because as you know, if you can communicate you can learn, you can work, pay taxes, participate in society and live more independently. With augmentative communication devices and support services children with disabilities can communicate their basic needs, go to school, learn, and live more independently enabling them to participate in the community and society at large. These individuals' basic rights to communicate may not have been possible under a managed care model or HMO, which in all probability would lead to foster care, more restrictive environments or institutionalization.

• Esteban v. Cook

Again at the end of the 1990's, after we worked to exhaust all options and remedies through year-long negotiations with AHCA, the Protection and Advocacy / TAP was left

with no other alternative but to file a federal class action to protect the rights of adults over age 21 with severe mobility disabilities who need prescribed medically necessary motorized or customized mobility devices (MCMDs) and services to live and to work in the community (see Attachment #2). One of the fundamental purposes of Medicaid is to help individuals with disabilities and their families attain or retain capability for independence or self-care, see 42 U.S.C. § 1396.

The availability of these motorized or customized mobility devices, since June 14, 1999, under Esteban v. Cook, enable adults with mobility disabilities to continue living in their homes, instead of the more-costly alternative of institutional care. Medicaid, by court order, must provide medically necessary durable medical equipment under prescription to individuals on Medicaid who need this assistive technology, training and support services to live and work in the community. These individuals' basic rights to MCMDs and all other durable medical equipment that is medically necessary under the Esteban v Cook court order may not have been possible under a managed care model or HMO, which in all probability would lead to more restrictive environments or institutionalization.

• Early Periodic Screening Diagnostic and Treatment (EPSDT) for children on Medicaid

These fundamental and basic human rights to Medicaid services for children must be protected at all costs. Our protection and advocacy programs receive numerous complaints that Medicaid refuses to provide basic durable medical equipment, therapies, medications, and other required support services. These complaints come from many credible sources, not only from working poor families who have children on Medicaid, but through such reputable entities such as officials with Shriners Hospital, nurses and other medical professionals who provide pediatric care, as well as providers and vendors. We are currently able to successfully negotiate most meritorious cases we receive against Medicaid without litigation because of the fundamental due process rights, which must be protected. However, a managed care model or an HMO could diminish or eliminate children's basic entitlements by denying the right to fundamental due processes under state and federal laws and regulations, which could leave working poor families with no choice but to give their severely disabled children up to foster care, more restrictive environments or institutionalization.

Florida, along with other states, is also under federal requirements that must be carefully considered in any systemic change recommendations. For example, the Omnibus Budget Reconciliation Act (OBRA) 89 amended §§ 1902(a)(43) and 1905(a)(4)(B), as § 1905(r) of the Social Security Act sets forth the basic requirements for the Medicaid program.

Under EPSDT, the Medicaid Act requires that any service which states are permitted to cover under Medicaid that are necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided to EPSDT participants (inclusive of children within families of the working poor) regardless of whether the service or item is otherwise included in Florida's Medicaid state plan.

President Bush's New Freedom Initiative and Priorities of the Olmstead Decision

As you know, President Bush announced the New Freedom Initiative February 1, 2001, as part of a nationwide effort to remove barriers to community living for individuals with disabilities. The current basic Medicaid supports and services are crucial to the Freedom Initiative and Olmstead decision.

Alternatives to a managed care model to remove barriers should be considered to improve access to Medicaid services, such as the timely provision of durable medical equipment and supports, therapies, and medications which can result in a cost efficient alternative to institutionalization by promoting community integration for elders and individuals with disabilities as these services given in the community are generally cheaper than institutionalization or placement in more restrictive environments. This is certainly in line with the goals and objectives of the Olmstead decision, promotes individual choice, self-sufficiency, community integration, economic self-sufficiency and remains consistent with the New Freedom Initiative helping to deinstitutionalize individuals with disabilities who have the basic human right to live and work in the community. This is also consistent with many provisions of State enabling statutes, such as Chapter 393.

• Recommendations

We respectfully recommend prior to any action on proposed Medicaid reform that the Florida Legislature assign a bipartisan Blue Ribbon Task Force, which could be monitored and independently reported on by the Office of Program Policy Analysis and Government Accountability (OPPAGA). The Task Force should consult throughout the process with the Centers for Medicare and Medicaid Services, investigate and thoroughly examine the effectiveness of any Medicaid managed care HMO models in other states.

The Blue Ribbon Task Force might also be comprised of individuals with disabilities, elders, and the working poor on Medicaid; disability organizations; protection and advocacy programs; doctors and medical professionals within and outside of managed care models; vendors/providers; and other state officials. The Blue Ribbon Task Force should be fully funded and staffed with the charge and responsibility to thoroughly investigate/study the ramifications of the Medicaid reform proposal, take expert testimony

in and outside of Florida, take additional public testimony, and provide an objective detailed analysis/written final report to the Legislature and the Governor.

Medicaid fraud and abuse

We would also like to recommend that the Legislature might consider substantial increased penalties to those who perpetrate Medicaid fraud, as fraud unchecked can eat up substantial amount of Medicaid's overall budget. For example, if fraud constituted 15% of the budget that would cost Florida tax payers over two billion dollars.

We also recommend, in conjunction with the Attorney General's Office, that a completely independent, well-staffed, fully funded, highly trained litigation department be organized and completely free to actively pursue all Medicaid fraud to court, which would not be susceptible to any outside influences or political pressure.

We want to again thank the Speaker of the House, President of the Senate and select committee members for the opportunity to comment. We trust with your careful scrutiny the basic human rights of our most vulnerable Floridians including children and adults with disabilities, elders, and the working poor can be protected.

UNITED STATES DISTRICT COURT SOUTHERN DISTRICT OF FLORIDA

ERIC HUNTER and CORY POWELL,

Plaintiffs.

vs.

CASE NO. 95-6881-CIV-GCNZALEZ

LAWTON CHILES, DOUG COOK, GARY CRAYTON, and GILBERT MITCHELL,

Defendants.

FILED by _____ D.C

OCT 2 5 1996

CARLOS JUENAE
CLERE U.S. DIST. CT.
S.D. OF FLA. FT LAUD.

FINAL ORDER

THIS CAUSE has come before the Court upon Defendants, Cook, Crayton and Mitchell's, Motion to Dismiss, Defendant Chiles' Motion to Dismiss, Plaintiffs' Motion for Summary Judgment, and Plaintiffs' Motion for Class Certification.

All motions have been fully briefed and are ripe for review. Additionally, there are no material factual disputes that exist in this case, the issues presented are questions of law and the case is ripe for adjudication.

The questions before the Court are whether federal law allows Florida to deny coverage of augmentative communication devices and services (ACDS) as durable medical equipment under its home health service program for its adult Medicaid recipients and whether Florida may deny coverage of ACDS for those under

FINAL ORDER

twenty-one (21) because of speculation that other payors may exist. The Court answers both of these in the negative.

I. FACTS

Plaintiffs Eric Hunter, age 22, and Cory Powell, age 7, are Medicaid recipients with severe speech disabilities. Both are unable to communicate either verbally or with hand gestures. Their treating professionals have determined that the only effective speech therapy for them is Augmentative Communication Devices and Services (ACDS) and that ACDS are therefore necessary for them. Without an ACDS, Plaintiffs are left without any oral speech or equipment for oral speech. Thus, they are predestined to depend on others and denied the opportunity to attain interdependence or self-care.

Plaintiffs, like many people with severe speech disabilities, are dependent on government benefits for access to ACDS which would allow them to communicate verbally. Plaintiff Hunter claims entitlement to an ACDS under Medicaid's Durable Medical Equipment program (DME); Plaintiff Powell claims entitlement under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. Defendants have a policy of not covering ACDS under the Florida Medicaid program. Defendants contend that ACDS are not covered for adult Medicaid

recipients, and are only covered for those under the age of twenty-one after all other funding sources have been exhausted.

II. MOTION TO DISMISS

Defendants argue that this case should be dismissed for three reasons: lack of venue, failure to state a claim and sovereign immunity.

A. Venue

This case can be brought in a judicial district where any defendant resides, if all defendants reside in the same State. 42 U.S.C. § 1391(b). Venue lies in the Southern District of Florida because all Defendants reside in Florida, Defendant Mitchell resides in the Southern District and the cause of action arose within the Southern District as to Plaintiff Hunter. Id. Thus, the motion to dismiss for lack of venue shall be denied.

B. Failure To State A Claim

When considering a motion to dismiss brought pursuant to 12(b)(5), a court must first accept all of the plaintiff's

All parties agree that for the plaintiffs to establish an entitlement to ACDS under Medicaid, the plaintiffs must show:
(1) they are eligible; (2) ACDS are covered; and (3) ACDS are medically necessary. It is undisputed that the Plaintiff's are eligible for Medicaid. The disputed issue is whether the ACDS are a covered service under the Florida Medicaid statute. Defendants neither concede nor deny that ACDS are medically necessary.

allegations as true. Scheuer v. Rhodes, 416 U.S. 232, 236 (1974); Thomas v. Burlington Industries, Inc., 769 F. Supp. 368, 370 (S.D.Fla. 1991). Consideration of matters beyond the four corners of the Complaint is improper. Milburn v. United States, 734 F.2d 762 (11th Cir. 1984); Thomas, 769 F. Supp. at 370. A court should not grant a motion to dismiss unless the plaintiff can prove no set of facts in support of his claim entitling him to relief. Conley v. Gibson, 355 U.S. 41, 45-46 (1957).

The Court finds that the complaint clearly states causes of action against Defendants Cook, Crayton, and Mitchell. Thus, Defendants, Cook, Crayton, and Mitchell's, motion to dismiss pursuant to 12(b)(6) shall be denied.

Regarding Defendant Chiles, however, the Court finds that the Complaint fails to charge Defendant Chiles with the violation of any law or duty. Although the Complaint charges the "action of defendants" in paragraphs 45, 46, 49 and 52 is in violation of various federal statutes, it fails to allege precisely anything connecting Defendant, Governor Lawton Chiles to such obligational violations. The complaint merely alleges that "Governor Chiles has the responsibility to ensure that the agencies of the Executive Department of the State, including AHCA, act in full compliance with the Constitution and laws of the United States."

Furthermore, it is not alleged that Defendant Chiles is factually or legally responsible for any program or activity that receives such funds or that he is responsible for AHCA's compliance with federal law or that he has any connection with or control over such program or activity. The Court finds that Plaintiffs have failed to state a claim which, if proven, would result in liability on the part of Defendant Chiles. Thus, Defendant Chiles' Motion to Dismiss shall be granted.

C. SOVEREIGN IMMUNITY

Defendants assert immunity based on Seminole Tribe of Florida v. Florida, 517 U.S. ____; 116 S.Ct. 1114 (1996), and argue that the Eleventh Amendment applies and therefore, the Court lacks subject matter jurisdiction over the Plaintiff's claims. The Seminole Court held that although Congress did intend to abrogate the State's sovereign immunity, Congress did not have the power to authorize suits by private parties against unconsenting States under the Indian Commerce Clause. The Supreme Court overruled Pennsylvania v. Union Gas Co., 491 U.S. 1 (1989), which held that Congress could authorize suits by private parties under the Interstate Commerce Clause.

A federal court has jurisdiction in a suit against a state officer, consistent with the Eleventh Amendment, to enjoin state officials to conform their future conduct to the requirements of

federal law. Ex Parte Young, 209 U.S. 123 (1908); Edelman v. Jordan, 415 U.S. 551 (1974). Although private individuals may not directly sue a state to enforce a provision of federal Medicaid law, they may sue state officials to obtain the same prospective relief. Such suits are not considered suits against the state itself and thus, are not barred by the Eleventh Amendment. Id.

In Seminole, the Supreme Court expressly acknowledges and affirms legal principles under which individuals have brought suits against state officials to enforce Federal Medicaid law. Seminole, at 1131-32 and nn.14, 16-17. Thus, the relevant law in this area is unchanged. In fact, the Court reaffirmed Congress does have the power to abrogate Eleventh Amendment immunity when legislating under the Fourteenth Amendment. Id. at 1125.

Plaintiffs' claims were brought under the federal Medicaid law, 42 U.S.C. § 1983, Title II of the American with Disabilities Act, 42 U.S.C. §12131, et seq., and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794. Defendants admit Seminole does not apply to claims brought under the Fourteenth Amendment. However, Defendants erroneously contend that Plaintiffs claims were not brought pursuant to the Fourteenth Amendment and that sovereign immunity has not been abrogated for the claims.

Congress explicitly abrogated the Eleventh Amendment in adopting the Americans with Disabilities Act. 42 U.S.C. § 120101(b)(4). The Rehabilitation Act Amendments of 1986 specifically overrode the Eleventh Amendment for both the Rehabilitation Act and all other claims of discrimination, including claims of Medicaid Act discrimination. 42 U.S.C. § 2000(d)-(7)(a)(1). The Court finds that Plaintiffs' claims are authorized by the Fourteenth Amendment. Further, the Medicaid Act is authorized pursuant to the Spending Clause of the Constitution of the United States. The federal government can attach conditions to federal funds so as to require States to honor the obligations assumed as a condition of receiving the federal funds. Metrolina Family Practice Group, P.A. v. Sullivan, 767 F.Supp. 1314 (W.D.N.C. 1989), aff'd, 929 F.2d 693 (4th Cir. 1991) (finding that Congressional control of federal funds is a valid exercise of the power of Congress under the Spending Therefore, Congress has both the power to authorize the § 1983 Medicaid Act claims and has abrogated the state's immunity from these claims.

The Court finds that the decision in Seminole does not affect the law governing whether individuals may bring suits to enforce the coverage of ACDS under Florida's Medicaid program.

Under the doctrine of Ex parte Young the case is not foreclosed

by the Eleventh Amendment because relief is limited to prospective injunctive relief. The holding in Seminole does not apply because Plaintiff's claims are authorized pursuant to the Fourteenth Amendment and immunity has been abrogated. Therefore, the Defendants' Motion to Dismiss for sovereign immunity shall be denied.

III. MOTION FOR SUMMARY JUDGMENT STANDARD

The Court may grant summary judgment "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Fed.R.Civ.P. 56(c). The stringent burden of establishing the absence of a genuine issue of material fact lies with the moving party. Calotex Corp. V. Catrett, 477 U.S. 317, 323 (1986). The Court should not grant summary judgment unless it is clear that a trial is unnecessary, Anderson V. Liberty Lobby. Inc., 477 U.S. 242, 255 (1986), and any doubts in this regard should be resolved against the moving party, Adickes V. S.H. Kress & Co., 398 U.S. 144, 157 (1970).

The movant "bears the initial responsibility of informing the district court of the basis for its motion, and identifying those portions of [the record] which it believes demonstrate the

u.S. at 323. To discharge this burden, the movant must point out to the Court that there is an absence of evidence to support the nonmoving party's case. Id. at 325.

After the movant has met its burden under Rule 56(c), the burden of production shifts and the nonmoving party "must do more than simply show that there is some metaphysical doubt as to the material facts." Matsushita Electronic Industrial Co. v. Zenith Radio Corp., 475 U.S. 574, 586 (1986). According to the plain language of Fed.R.Civ.P. 56(e), the non-moving party "may not rest upon the mere allegations or denials of the adverse party's pleadings," but instead must come forward with "specific facts showing that there is a genuine issue for trial, "Fed.R.Civ.P. 56(e); Matsushita, 475 U.S. at 587.

Essentially, so long as the non-moving party has had an ample opportunity to conduct discovery, it must come forward with affirmative evidence to support its claim. Anderson, 477 U.S. at 257. "A mere 'scintilla' of evidence supporting the opposing party's position will not suffice; there must be a sufficient showing that the jury could reasonably find for that party."

Walker v. Darby, 911 F.2d 1573, 1577 (11th Cir. 1990). If the evidence advanced by the non-moving party "is merely colorable, or is not significantly probative, then summary judgment may be

granted. * Anderson, 477 U.S. 242, 249-50.

IV. THE MEDICAID STATUTE

The purpose of the Federal Medicaid Act is to enable each State "to furnish.... rehabilitation and other services to help such families and individuals attain or retain capacity for independence or self-care..." 42 U.S.C. \$ 1396(2) (1992).

Augmentative communication devices have been found to "fall within the general purpose of the Medicaid statute." Fred C. v. Texas Health and Human Serv. Comm'n, 1996 WL 226992, 1 (W.D. Tex.). Florida chose to participate in Medicaid, 42 U.S.C. \$\$1396-1396v, a joint state-federal funding program for the needy. "Although participation in the Medicaid program is entirely optional, once a state elects to participate, it must comply with the requirements of Title XIX." Harris v. McRae, 448 U.S. 297, 301, (1980).

Federal law does not require states participating in the Medicaid program to provide all services and devices which come within the general purpose of the statute. Rather, Congress requires a state Medicaid program to provide, at a minimum, "at least the case and services listed in paragraphs (1) through (5), (17) and (21) of section d(a) of this title." 42 U.S.C. \$1396a(a)(10)(A) (Supp. 1996).

States may decide to provide any of the optional medical services listed in Title XIX of the Social Security Act. 42 U.S.C. §1396d (Supp.1996). Home health care is an optional service. Id. Florida has elected to cover Home Health Care Services and Early and Periodic Screening, Diagnosis, and Treatment Services, both of which include durable medical equipment, as Mandatory Medical Services. Fla. Stat. §409.905 (4), (2) (1996).

Regarding Plaintiff Hunter, the issue is whether augmentative communication devices fall within the optional service of home health care listed in Title XIX which Florida has elected to cover under its Medicaid program. Once a state chooses to cover one of the optional services which could possibly provide Medicaid funding for augmentative communication devices, that state is required to provide ACDS. Meyers v.

Reagan, 776 F.2d 241, 244 (8th Cir. 1985). The Medicaid Statute in Meyers included "physical therapy and related services" among the optional services. Id. at 243. "Related Services" is defined by Federal regulations to include services for individuals with speech, hearing, and language disorders. Although the state of Iowa provided for coverage of physical therapy, it excluded ACDS. Iowa contended it had broad discretion in determining the extent of medical services it offered and could exclude ACDS from

coverage. Id. at 243-44. The Court disagreed and found that "[O]nce Iowa chose to offer "physical therapy and related services," it bound itself to act in compliance with Title XIX of the Social Security Act and the applicable regulations in the implementation of those services....Thus, Iowa cannot arbitrarily exclude electronic speech devices from coverage under its Medicaid program." Id.

Although Florida Medicaid has not elected to provide "physical therapy and related services," it does provide the optional service of home health care. Fla. Stat. 409.905(4) (1996).

V. HOME HEALTH CARE AND DURABLE MEDICAL EQUIPMENT

The Federal Medicaid statute specifically includes "home health care" among the optional services, and federal regulations define "home health care" to include "durable medical equipment." 42 U.S.C. §1396d(a)(7) (Supp.1996); 42 C.F.R. §440.70(b)(3)(1995).

Plaintiff Hunter claims entitlement to ACDS as durable medical equipment (DME) and argues that ACDS are required to be covered under the Durable Medical Equipment (DME) program.

Defendants do not deny that ACDS meet the generic characteristic of durable medical equipment nor do defendants deny that ACDS are

and younger. In fact, Defendants contend that the Florida
Medicaid program "does not cover augmentative communication
devices as durable medical equipment for adults" and "does not
cover augmentative communication devices for Medicaid recipients
under 21 years of age because those devices are available"
through other sources. Welch Aff. at 2. The defendants thus
contend they would pay for an ACDS for those younger than twentyone if they were the payor of last resort but would never provide
an ACDS to those twenty-one years one day and older. The
Defendants contend that they "have the discretion to choose what
optional services will be covered, and whether those services
will apply to both adults and those under the age of twenty-one
(21)." Defs. MD Mem. at 7. The Court disagrees.

Medicaid funding cannot be denied on the basis of age.

Salrado v. Kirschner, 878 P.2d 659, 660 (Ariz.1994) (enbanc),

cert. denied, 115 S.Ct. 1102 (1995). In Salrado, a Arizona

Medicaid program participant was denied lifesustaining liver

transplant coverage because she was over twenty-one. Id. at 660.

The state, like the defendants in the instant case, argued it

could choose to provide transplants to children and not to adults

because the federal Medicaid statute allowed EPSDT services for

those under twenty-one Id. at 662. The Court disagreed and

found it unreasonable to allocate treatment within a service category solely on the basis of age. This Court finds that Florida Medicaid's selection of age as the sole criterion for denying benefits is wholly unrelated to the medical decision at hand and cannot meet the fundamental legal concept of reasonableness. See Fred C. at 4.

Federal Courts have also held that a denial of Medicaid benefits based upon age must satisfy the rational basis test.

Peck v. Califano, 454 F.Supp. 484, 488 (D.Utah 1977).

Additionally, state Medicaid decisions as to coverage "must have a rational basis for the distinctions they draw." Curtis v.

Taylor, 625 F.2d 645, 650 (5th Cir. 1980); Fred C, at 4.

The regulations accompanying the Medicaid statute state that each covered service "must be sufficient in amount, duration, and scope to reasonably achieve its purpose." 42 C.F.R. §440.230(b) (1995). The general purpose here is "to furnish... rehabilitation and other services to help.... attain or retain capacity for independence or self-care..." 42 U.S.C. § 1396(2) (1992). The specific purpose is "to augment verbal communication through the program's home health care/durable medical equipment service." Ered C, at 4; See 42 U.S.C. § 1396d(a) & (7) (Supp.1996). The ability to speak and communicate is vital and ACDS have enabled Medicaid recipients with severe speech disabilities "to live on

their own, maintain employment, pay taxes, and become productive members of the community rather than wards of the state. This limits the cost of other disability and other welfare benefits. Fred C, at 4 (citing Helping the Mute to Speak, 17 N.Y.U. REV. L. & SOC. CHANGE 741 (1989/1990)). This Court concludes that there is not a rational basis to provide speech to one who is twenty years three hundred sixty-four days and deny the same to one who is two days older. Fred C, at 4.

The Court finds that Florida made the voluntary choice to provide optional home health care, including durable medical equipment, to the Plaintiffs. The Court concludes that the ACDS is durable medical equipment and covered as a Florida Medicaid benefit under the home health care provision.

VI. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT

Plaintiff Powell claims entitlement to ACDS under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program and argues that ACDS are covered under the Early and Periodic Screening, Diagnosis and Treatment program (EPSDT) as speechtherapy, DME, prosthetics and rehabilitation services.

Defendants do not dispute that ACDS are covered by EPSDT for children if found to be medically necessary for that child.

Cook's SJ Mem. at 3. Defendants' only defense to their policy of

excluding ACDS from Medicaid coverage is their argument that Medicaid is the "payor of last resort." Id. at 3-4. The Defendant speculates that ACDS are available through Children's Medical Services, the Departmental Services Program, and various school districts.

The Court finds Defendants statements to be self-serving and conclusory. Plaintiffs have provided substantial evidence that other funding has not been made available to Plaintiffs.

Plaintiff Powell has repeatedly tried to obtain ACDS from many sources without success. Similarly, Plaintiff Hunter has tried without success for more than six years to get Medicaid and other agencies to provide ACDS.

The Court determines that the Plaintiffs do not have private funds such as private insurance available to them and that the government sources submitted by Defendants are not required by law to provide ACDS to Medicaid recipients such as Plaintiffs.

Developmental Services has extensive waiting lists for services.

The Florida Developmental Disabilities Council does not provide direct services and has advised the Court that it will not provide ACDS to Medicaid recipients generally and in specific to Plaintiffs. Both Children's Medical Services (CMS) and Department of Labor and Employment Security Division of Vocational Rehabilitation (DVR) require that the clients first

avail themselves of other rescurces before becoming eligible for services through their programs. See Fla. Admin. Codes § j-2.006 ("every possible alternative financial resource will be investigated" by CMS staff); 29 U.S.C. §721(12)(A) (for eligibility of DVR services DVR must show that "comparable services and benefits are not available under any other such program" and that "maximum utilization shall be made of public or... other appropriate resources"). CMS specifically lists Medicaid as an alternative financial resource to be used prior to CMS funds. Fla. Admin. Code \$10J-2.006. DVR is allowed to subrogate Medicaid for medically necessary items. F.S. 413.445 (1993). Furthermore, DVR's principal mission is to promote employment for individuals with disabilities, not to meet the medical needs of young children who do not meet the minimum age for engaging in most work activities. The Court finds that DVR, CMS, and Medicaid could all argue that they are the payor of last resort with the result that no agency agrees to pay for the device.

Defendants may not relieve itself of its obligation to provide ACDS under EPSDT by pointing to local school districts and their responsibilities to provide special education services. The Medicaid statute clearly states that the availability of special education funds cannot be used to deny medically

necessary services under Medicaid. 42. U.S.C. §1396(c). Nothing in the Social Security Act

shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to a child with a disability because such services are included in the child's individualized education program established pursuant to part B of the Individuals with Disabilities Education Act or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part H of the Act.

42. U.S.C. §1396b(c) (Supp. 1996).

Medicaid regulations provide that Medicaid must pay if probable liability of a third party is not established or benefits are not available at the time the claim is filed. 42 CFR § 433.139(c). The Court finds that Defendants have not established the probable liability of a third party or the existence of available benefits. The Defendants are obligated to provide ACDS to the Plaintiffs and cannot deny coverage because of speculation that other payers may exist.

VII. MEDICALLY NECESSARY

Once services are covered, the next issue is whether the

That provision states: "If the probable existence of third party liability cannot be established or third party benefits are not available to pay the recipient's medical expenses at the time the claim is filed, the agency must pay the full amount allowed under the agency's payment schedule." 42 CFR §433.139(c).

covered service is medically necessary. The federal Medicaid regulations authorize states to apply a "medical necessity" standard to requests for covered services. 42 C.F.R. § 440.230(d). See Beal v. Doe, 97 S.Ct. 2366 (1977). Florida Medicaid utilizes the following definition of medical necessity:

"Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:

- (a) meet the following conditions:
- (1) be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- (2) Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
- (3) Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
- (4) Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- (5) Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider."

F.A.C. §59G-1.010(167).

The Court finds that the Plaintiffs satisfy this definition.

The Plaintiffs have severe speech disabilities and have been evaluated by certified speech-language pathologists. These experts determined that the only speech-language pathology treatment methodology that will allow the Plaintiffs to have effective expressive communication is the use of ACDS. Phipps

Aff. at 5; Ronczkowski Aff. at 4. The determinations were based, in part, on the lack of success prior speech language pathology services have had in allowing the plaintiffs to produce speech organically. The experts state that ACDS treatment is appropriate only when other forms of treatment will not allow a patient to naturally produce speech.

"The determination of medical necessity must rest with the individual recipient's physician and not with clerical personnel or governmental officials." Pinnecke v. Preisser, 623 F.2d 546, 550 (8th Cir. 1980). The experts who evaluated Plaintiffs found that ACDS will prevent significant disability or alleviate severe pain; is consistent with generally accepted professional medical standards as determined by Medicaid; is reflective of the level or service that can be safely furnished, and there is no equally effective and more conservative or less costly treatment available; and is furnished in a manner not primarily intended for convenience. The Plaintiffs treating professionals have determined that the only effective speech therapy for them is Augmentative Communication Devices and Services (ACDS) and that ACDS are therefore necessary for them. Phipps Aff. at 2; Ronczkowski Aff. at 2. Based on the foregoing the Court finds that ACDS is medically necessary.

The Court holds that the augmentative communication device

is medically necessary and is a covered benefit for both adults and children. ACDS are durable medical equipment and covered as a Florida Medicaid benefit for adults under the home health care provision. For children, ACDS are covered by the early and periodic screening, diagnosis and treatment program. The Court concludes that Defendants are obligated to provide ACDS to children and adults and cannot deny coverage to anyone because of speculation that other payors may exist. Thus, Plaintiffs' Motion for Summary Judgment shall be granted.

Having reviewed the motions and the record, and being otherwise duly advised, it is hereby:

ORDERED AND ADJUDGED that Defendants, Cook, Crayton and Mitchell's, Motion for Leave to Amend Motion to Dismiss, filed May 6, 1996, is GRANTED. It is further hereby:

ORDERED AND ADJUDGED that Defendants, Cook, Crayton and Mitchell's, Motion to Dismiss, filed October 10, 1995, is DENIED. It is further hereby:

ORDERED AND ADJUDGED that Defendants, Cook, Crayton and Mitchell's, Amended Motion to Dismiss, filed May 6, 1996, is DENIED. It is further hereby:

ORDERED AND ADJUDGED that Defendant Chiles' Motion to Dismiss, filed October 23, 1995, is GRANTED. It is further hereby:

ORDERED AND ADJUDGED that Plaintiff's Motion for Class Certification, filed October 31, 1995, is DENIED. It is further hereby:

ORDERED AND ADJUDGED that Plaintiff's Motion for Summary Judgment, filed October 31, 1995, is GRANTED.

Plaintiffs are hereby DIRECTED to file a proposed form of Final Judgment for entry herein within twenty (20) days from the date of this order.

DONE AND ORDERED in Chambers at Fort Lauderdale, Florida,

this 24rd day of October, 1996.

JOSE A. GONZALEZ, JR

WITED STATES DISTRICT JUDGE

cc: All counsel



2671 EXEC. CENTER

CIRC. W. . SUITE 100

TALLAHASSEE FL 32301-5092

(850) 488-9071

(850) 488-8640 (FAX)

(800) 342-0823 (VCICE)

(500) 346-4127 (TDD ONLY)

July 30, 1999'

Motorized and Customized Mobility Devices

IMPORTANT VICTORY for INDIVIDUALS WITH DISABILITIES!!!

Attention all individuals with disabilities, parents, guardians, representatives, doctors, physical therapists, other medical personnel, advocates, advocacy groups, disability organizations and other interested or affected parties.

A victorious class action litigation set an important case precedent for individuals with disabilities on Medicaid.

The Advocacy Center for Persons with Disabilities Inc.'s Technology Assistance Program (TAP) is pleased to report that U.S. District Judge Donald L. Graham issued a precedent setting Final Order on June 14, 1999 (see attached), which prohibits the Agency for Health Care Administration's Medicaid program from denying medically necessary motorized and customized mobility devices (MCMDs) under prescription as durable medical equipment (including 3 motorized wheelchairs and other customized motorized mobility devices) for individuals who qualify for Medicaid. 2901 STRLING ROAD Further, this Order prevents Medicaid from using a list of predetermined covered items as an exclusive list of medical sim 206 equipment Medicaid covers as durable medical equipment.

FT. LAUDERDALE FL 33312

Important information for doctors, medical professionals, individuals with disabilities and their representatives who (954) 967-1493 seek to receive Medicaid's approval for MCMDs. Doctors and other health care professionals should review the attached (%) %7-1496 (FAX) Order before writing a prescription and must be aware that MCMDs, as durable medical equipment, are required to be (800) 350-4566 verified as medically necessary. Prescriptions should clearly detail all the reasons a MCMD is medically (VOICE TOD OR ESPANOL) necessary, accordance with in the attached incorporating exact specs, proper seating and positioning, including a physical therapist evaluation with prescription.

Judge Graham's June 14th Final Order granted a judgment in favor of our 14 named individual plaintiffs, insuring that they and, most importantly, the classes of individuals with disabilities they represent will get the MCMDs they need.

This class action litigation was filed by the Advocacy Center's TAP program because of illegal provisions in Florida's Medicaid plan that previously capped coverage for wheelchairs and other mobility devices for adults at \$582. That limitation had the effect of preventing adults from obtaining MCMDs even when those devices were certified as medically necessary. This, in turn, directly impacted the ability of individuals with severe disabilities to be mobile and excluded them from being able to fully participate in major life activities.

This class action litigation, brought by the Advocacy Center's TAP program, will help insure that all Floridians who qualify for Medicaid will finally be able to get MCMDs under prescription that are medically necessary. Please be aware that this Final Order also includes an extremely important provision for the repair of MCMDs.

Thank you in advance for circulating this important notice and attached Final Order to individuals with disabilities, guardians, representatives, doctors, physical therapists, other medical personnel, advocates, your staff, constituents, grassroots advocacy groups, disability organizations and all other interested or affected parties.

Steve Howells, Director Technology Assistance Program UNITED STATES DISTRICT COURT SOUTHERN DISTRICT OF FLORIDA Case No. 97-2830-CIV-GRAHAM

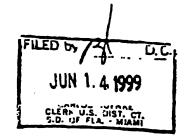
MANUEL ESTEBAN, et al.,

Plaintiffs,

vs.

DOUG COOK, et al.,

Defendants.



FINAL SUMMARY JUDGMENT

THIS ACTION came before the Court on Plaintiffs' Motion for Summary Judgment (D.E.# 33) and Plaintiffs' Motion for Class Certification (D.B.# 11).

THE COURT has considered the Motion and the pertinent portions of the record, and in accordance with the Amended Order granting Summary Judgment (D.E.# 84) and Amended Order Certifying Class (D.E.# 83), and being otherwise fully advised in the premises, it is

ORDERED AND ADJUDGED that Final Summary Judgment is hereby entered in favor of Plaintiffs against Defendants. Plaintiffs' Motion for Class Certification (D.E.# 11) is GRANTED. The certified class is defined as:

all Florida Medicaid and Medicaid eligible individuals who have been diagnosed with severe mobility impairments and are over age 21 and who need or will need motorized and

customized devices and services as prescribed by their treating professionals.

ORDERED AND ADJUDGED that Defendants are hereby enjoined from using the list of covered items as the exclusive determinant of Medicaid coverage for Durable Medical Equipment. It is further

ORDERED AND ADJUDGED that Defendants are DIRECTED to reprocess Plaintiffs' requests for coverage in compliance with the Court's Amended Memorandum Opinion (D.E.# 84) within 30 days from the date of that Opinion. In addition, costs and attorneys fees in this action may be taxed at a later date upon the appropriate motion.

DONE AND ORDERED in Chambers at Miami, Florida, this 144 day of June, 1999.

DONALD L. GRAHAM

UNITED STATES DISTRICT JUDGE

CC: Thomas Falkinburg, Esq. Ellen Saideman, Esq. Peter Nimkoff, Esq. Judy Gallagher, Esq. Please make sure your doctor, therapist and medical supply company have this information. Your doctor must verify the medical necessity. Your physical therapist must provide a report and your medical supply company will need to understand this class action procedure, particularly as it relates to the prior approval billing procedure explained on the Medicaid website attached to this notice. Also keep a copy for your records.

For detailed information on the prior approval billing procedure for durable medical equipment, including motorized and customized mobility devices, contact the Medicaid website at:

www.fdhc.state.fl.us/Medicaid/index.shtml

After you type the address in, scroll down to the bottom of the page to access provider information.

Feb 10, 2005

To Whom It May Concern: My name is Clear Sangley, I am a dialysis patient getting three treatments a week, I have June 28, 1995. Jan a widow I last my hiesband in Uct. 1999. I have a trailer payment, I lease my Car to make Sure that I have good transportation when going to the dialipsis Center, three treatments a Share I Cost Trogram - with my share of Cost being 4,179.00 per month. Cast of my medications is 3,238.30 and this is not all of my medicines. I am under 65 - Jan 5 Hegar old - will not reach 65 until Dept 26,2015 this is) 11 more years before I'll reach 65. Since, Jan under 65 so would not be eligible for any drug assistance Through aprogram In the elderly That The Governor is proposing.

Opposition to angoldense in the

Medically Reeder Program Stithout the assistance I receive from them, I could not line. On my own and many of them are not Covered by the Indigent Drug Program. Oh! did I forget to tell you that the Cost of Freatment are Hemo in \$275,00 plus EPO \$ 70.00 345.00 ×3 times a week is #1,035 per week The Demo treatment is what I am ON at the dialysis Center. P.D. in \$57.00 EPD \$70.00 \$ 847.00 per week. P.D treatment is doing this treatment Gourself at home. Therefore if you vote for eleminating this program you are signing my death warrant. Thank you for your time and Consideration of my opinion

Jwould like to invite lack and Iveryone to visit My dialysis Center in Ocala and see what I am paying, The address is DAVITA Ocala Regional Hidney Center 3870 S.E. 1 A Ave. Ocala, Fla 34471 tel - 352 351-9140 Fax 352-351-9150 E-mail 4020 davita, Com.

There are more and more people going on dialipies overyday. This center han 30 Chairs & 3 shifts per day. I am there on Mon, Wed, Fre and Others, are there, Ine, Thus, Sat, Kla Vita in Marion County has a total of 4 units. Be surprise just how many of us that needs help. On, just pick any town and just drop by and visit with the people.

(394)

Thank you for your time. Sincerely, Seen Mareley 2820 N.W. 18th St. Ocala, Florida 34475-4735 As If you had to Choose between disfipis treatment and living to your loveryday needs like I may need to Choose, which One would you Choose? This is what is Coming down to for me. Ether way I can not survive without bath.

(4o74)



Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review.

Name:	BILL CULHANE
Association:	PARENT OF SON WITH INTERESTUAL DISATSILITIES
Address:	1707 DONGASTER RO CLEARWATER RL 33764
-	CLEARWATER EL 33764
(Please use the	front and back of this sheet to provide your information.)
	PLEASE SEE ATTACHED
	1 TONGE SEE ATTACHED

JOINT REGIONAL PUBLIC HEARING ON MEDICAID REFORM TAMPA, FLORIDA FEBRUARY 11, 2005

MEDICAID

Florida implemented the Medicaid program on January 1. 1970, to provide medical services to low income children and families and the aged, blind, and disabled. Income, age, and asset limits vary. Medicaid is funded through federal and state participation with counties contributing to the cost of inpatient and nursing facility services. Florida Statutes authorize the Florida Medicaid Program. It is administered by the Agency for Health Care Administration.

MEDICAID WAIVER

The federal Omnibus Reconciliation Act of 1981 authorized the Secretary of Health and Human Services (HHS) to waive federal requirements to allow states to provide home and community-based services to individuals who would require institutionalization without these services. The state of Florida has approximately ten of these waiver programs. Medicaid reimburses for home and community-based services for waiver-enrolled Medicaid recipients who meet the target group criteria. Home and community-based services cannot be provided to recipients who reside in hospitals and nursing facilities. Two waivers, the Developmental Services Home and Community Based and Supported Living Waivers are limited to individuals who are at risk of placement in an intermediate care facility for the developmentally disabled (ICF/DD).

DO NOT INCLUDE DEVELOPMENTAL SERVICES HOME AND COMMUNITY BASSED AND SUPPORTED LIVING WAIVERS IN MEDICALD MODERNIZATION PLAN

The Agency for Persons with Disabilities has already met the Governor's modernization goal for the developmentally disabled community. Persons can be placed on the Waiver only when funds allow, (15,000 persons now waiting for service). For those on the Waiver, a specific amount of money, based on services needed, is available for each individual each year. It is called the Cost Plan and the amount is approved by the state. Waiver participants currently can obtain services from the vendors of their choice, if qualified. In the past two years the state has paid hundreds of thousands of dollars for studies that have lead to standardized rates for services throughout the state. In fact, while many Medicaid services, such as pharmaceuticals, have increased drastically in the past few years, the standardized rates for the developmentally disabled have actually decreased for day and residential programs. The escalation of costs of the Medicaid program in Florida, and nationally, is driven by health and long-term care costs. The Medicaid Waiver program for the developmentally disabled is less than 10% of the state's Medicaid budget. The Governor's budget and legislative action control the spending with the Waiver program, not the open ended commitment found the in the rest of the Medicaid program. For all of the above reasons, I recommend that the Medicaid Modernization not include the Developmental Services and Supported Living Waivers.



Medicaid Reform Public Hearing

February 11, 2005 Tampa, Florida

Presented by:
Deborah (Dee) and Timothy M. Bird
5334 Granada Blvd
Sebring, FL 33872
863-385-1856

- Hello, My name is Deborah Bird and this is my son, Timothy.
- We currently live in Sebring of Highlands County
- I am a single parent, on disability, and my son lives with me.
- My son Tim currently has a "permanent disability", which is life-threatening. He has Duchenne Muscular Dystrophy.

Because of Medicaid, our family has been able to receive assistance with medication and hospitalization. For Tim, due to his high risk, he is hospitalized often. He is at high risk now due to Cardiomyopathy and with respiratory issues. These are the complications that may take his life as primary, with muscular dystrophy being secondary. Although I pay through the Healthy Kids-Children's Medical Services, these services often help with daily medical care, hospitalization, nutrition, dental and eye exams. Something I could not afford due to my income.

Because of my disability, I'm on limited income...for two years I did not have anything until my Medicare kicked in. Although I am currently on the Medical Needy (share of cost), this aids me with my \$1200 of medication, it help with my Medicare premiums and works as a secondary for my medical and hospitalization stays.

Keeping the Medicaid program is important to us, but that doesn't mean there aren't problems that need to be fixed

One of my biggest concerns for our family and others like us is: the Medicaid office

currently denies a lot of his needs due to the Muscular Dystrophy Association. Let me explain: they are misinformed how the MDA really works. They believe that the MDA provides a lot of things for their clients, when they actually don't. However, the Medicaid office has this belief that we first must go the MDA to receive a lot of these services. The MDA does NOT cover many of the needed equipment, nor do they cover it as a primary insurance, and although they are not an insurance company, if you don't have insurance, they will cover the MDA clinic care and certain medical equipment as primary (if it is covered), but they do not cover hospitalization and much needed other equipment.

My second concern is that there are not many Medicaid waivers (for home and community based care) in the state of Florida; and what there is, they do not cover for Muscular dystrophy, simply because they think the MDA provides it, which is their wrong conception. Since Medicaid (including CMS) does not cover many services, especially needed medical equipment, we have to find other resources to fund the equipment... but then at times we are penalized for obtaining these funds and it is looked at as "extra income." These are some things that need to be fixed.

Because of this, we think this reform will definitely make things much more difficult and stressful for parents and Medicaid recipients to receive the proper care and treatment by physicians who are pressured to get the patient in and out under a short period of time; and if the policy caps out, what do we do next?

Our children's lives depends on the proper treatment and care for a productive long life. When and if we have to work with HMO and PPO physicians, which most are clueless and ignorant about Muscular dystrophy, much less the proper treatment, then it will definitely give these individuals a death wish. Uneducated insurance companies and physicians, (and at times even Medicaid), has a way of playing "Russian Roulette" and deny many of the medical care, including physical therapy, surgeries, nutrition, & medical equipment because they believe that the boys will die by the time they are 20 years old due to an old text book theory. But what they fail to understand there is plenty of proof that boys with DMD can live productively into their 20's and 30's or longer when provided with proper treatment and care. We cannot gamble with people's lives. This potential Medicaid reform will indeed give them that opportunity. Medicaid is not what needs to be reform, but the general heath care. The Health care in America needs a reform first before giving them this responsibility to take over Medicaid.

I believe that the only way we will ever help families like ours is to consider the important needs of proper care and treatment that individuals with disabilities must have, and look at the opportunity of giving them the hope and dreams they deserve for today and tomorrow. Consider how this reform will only cause more damage to families who like us depend on it due to our disabilities and our income. Asking us to pay a larger premium or co-payment will add much more stress, anxiety; and our disability or/and illness will suffer much longer due to the pressure of health care cost laid upon

us. Allowing insurance companies to cut our services so they can make money is not fair. Please don't ask us to make any more sacrifices then what we already have made to care for our disable individuals and children.

Conclusion

I believe that Governor Jeb Bush needs to take into consideration, that there are many families here who do not have the income to pay for such premiums, co-pays or services that are not covered or are capped; much less deal with insurance companies who don't care about proper treatment. To them, it is about the money, it is not about the care. I'm not sure where he thinks we will be able come up with this extra money to pay when we, as it is, barely survive. I thought that is what Medicaid was about to help the disable and the poor. This reform will not help the disable, nor will it give them the means to survive on.

We are trying to understand why Governor Jeb Bush took away the taxes on Alcohol and cigarettes...rewarding those who manufacture and sell items that are destructive to the human body...making people ill and killing them; and yet he is "punishing" the poor and disable by cutting funds for safety net programs and Medicaid. Why not continue to tax these items as their "punishment" and use that money in the Medicaid program, etc...it does not make a wrong right, however, why should the innocent be punished and the very thing that destroys us be rewarded? It contradicts itself. It does not make sense. So instead of a reform, why not fix problems such as this and help make a difference for those who do deserve the proper care.

Please take into consideration of the disable and poor, those of us who are single parents and who struggle day in and day out, making our own sacrifices to struggle to save our children's lives. The propose Medicaid reform will only destroy us physically, mentally, emotionally and financially. We, who once worked and paid our taxes, should not be punished for being ill or having an ill child.

On behalf of my family and the thousands of others like us, we would like to thank you and tell you that your attention to developing a solution with us can mean a real difference in the lives of families, who is affected by Muscular dystrophy or a Mental Health condition.



Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review.

Association: I Yieng full Cinqui
Address: 1888 Brother Geenen Way
Sarasota, F234236
(Please use the front and back of this sheet to provide your information.) As a Lead agency for a five vicinity area in SWPL we applement the applement of the country area in SWPL we applement the country area in SWPL we apple the country area in SWPL we apple to the country area.
the Governor's & Legislature's efforts toward Medicard Reform & we want
to work with you in this effort. Lead agricus have a record of 20-70
years of establishing a retwork of services to assist fail elders
to age in place + avoid institutionalization. Senior Friendship
Centers of Sorasota, in particular, has a 32 year history of providing
not only government bunded services, but privately funded services
including Health & Dertal Chies that serie individuals 50

+ older within 20090 of the poverty guidelines through the Frices of almost 100 volunteer physicins, as well as volunteer dentists, nurses of dental hyggerists; Senior Centers. providing reacheful social interaction is recomeding our now Friendship at Home/Faith in action program which utilizes Volunteers to provide services to Homebound Elders as well as organy faith Communities to become more procetive in identifying elders in need & serving as Volenteers to those in their community. These programs, networks I series how taken decade to establish and could be threatened by directing & from current Med. Waiver programs. Please include Lead agencies in the planning for this reform. We want to continue to be an integral part of protecting our most fail & vulnerable elders from promotive institutionalization. One other rote - the current medicaid waver programs for Older adults start@ age 60 but the proposed water identifies age 65 + above. Could agus programs be granted on exception from this, while this gas is evaluated.

1-Note on Novely Home Diversion Program / Homo's-Taking on what Lead agains have done for 2-3 decades @ greater Doubts of giving \$ to Par Profit Industries. Expend \$ to Cornert Lead Against rather than I have Exchalit Homo's deposit less Nursing Home Radio

spuhe

The Florida Legislature Senate Select Committee on Medicaid Reform House Select Committee on Medicaid Modernization Public Hearing Comment Form



Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

any comments yo	nu may have on the Governor's proposal to reform Medicald.
Please use this fo during the public I	orm if you would like to provide information to the Committees, but do not want to speak hearings. All forms will be made available to the Committee members for their review. (U.
Name:	BICHARD C. DRSTEIN - [GOV. APPOINTEE-STATEWIDE ANNULANT.
Association: 💆	MITENSIDE AUXOCACY COUNCIL - PINECIAS-PASCO REP. COUNCI
Address: /	191 NIGOGG CIA. PARINHARBON, Ph 39663
_	
(Please use the	front and back of this sheet to provide your information.)
NENTAL 4	FACTH CLIENTS
THE NEWER	MEDICATIONS ARE SIGNIFICHNICY MORE EFFECTIVE
THAN THOSE	15 YAS OLDER - BUT MORE EXPENSIVE. HOWEVER
ANY ATTEM	PT TO PLACE LIMITS ON INDIVIDUALS MEDICATION
CosTS 15 5	HORT SIGHTED IN DOLLAR TERMS AND MORALLY
UNACCEPT	ABCE.
D CUT BACK	15 ALREADY HAVE REDUCED THE AVAILABILITY OF
	UT DAY MOGRAMS. THIS LEAVES CLIENTS RECOVERING

	ROM BARAKDOWAS STARING AT WALLS 24 HAS PER DAY WHICH
	15 TANTAMOBENT TO A MAJOR SETBACKIO
	THERE HAVE BEEN OUT BACKS ALREMOY ON SUPPURIED LIVING FUNDS
<u>८</u>	WORTHATELY, THIS HAS RESULTED IN MASOR REDUCTIONS IN
<u> Sq</u>	PERVISED CARE HOUSING, RESULTING IN JAILINGS, HOSPITALIZATIO
AN	VID YES SEVERAL DEMTHS. THIS MUST BE IDEACT WITH.
1	A CAREFUL LOOK AT WHAT IS REALLY HAPPENING IN THE
<u>Në</u>	NTAL HEALTH FIELD 15 EBSENTIAL. Dr MUST BE DONE BY
N	DEPENDENT KNOWLEDGABLE PERSONS.
,	Whenter Fales
AU	ING-S
11	AVE SUGGESTION FOR SAVING MILLIONS
G	AN ONLY BE UNDERSTOOD BY ONE ON ONE MITE. WITH CITHER REP. WATER. GNO/OR REP. BERTIE
	grofor REP. BERFIL



Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review.

Name: 11+tagy Reid
Association:
Address: 2509 17th Ave W
Bradenton, FL 34205
(Please use the front and back of this sheet to provide your information.)
Medicaid needs reform. Do not balance your budget on my back.
Focus on Asset Sheltering laws and providers, patients + vendors who
defraud medicaid. Privatization of medicaid will not work for the
thousands of people who are considered uninsurable. They will still
be uninsurable. Catastropic coverage comes with a cap- you will dictate
how sick people are allowed to be. Altogether my medical bills are
over 250,000 per year. I will be taken off the transplant list if
medicaid is gone. You have already cost me my husband, don't cost me
my life please.

	Medicaid is the only sofety net for hundreds of thousands of Floridian
	and you can't put all of us in a sink or swim system. Many thousa
	will Surely Slok.
	My children need their mother. Their mother needs a transplant.
	Don't take away my only chance to see them grow up.
,	Tyjany & Reis
•	on behalf of myself,
, .	Damon age 11. Zue age 8 and
-	Save money by Fixing - Nikita, age 5.
-	- Medicaid fraud
_	- Asset Shultering - big business For lawyers, should be illega
_	- Home based care - mursing homes are outrageously expensive
	- Prescription drug prices -
	- Using emergency owns as princy are-
	WE ARE PEOPLE, NOT NUMBERS
	Please cesture hospitalizations + doctor coverage
	to medically needy!!



Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review.

Name: Louise Port
Association: NEW HORIZOWS GROUP HOMES
Address: 109-115 EAST Clay Au.
BRANDON, FL. 33570
(Please use the front and back of this sheet to provide your information.) I REPRESENT A SMALL ASSISTED LIVING FACILY FOR
12 MENTALLY CHALLANGER INDIVIDUALS. WE CURRENTLY
RECEIVE MEDICAID WALVER RESIDENTIAL HABILITATION
Funding for most of our RESIDENTS. During the
Cut BACKS LAST TIME WE LOST OVER 63 % OF
our Funding. His is A Spacifich NETEDS population
that NEEDS SERVICES - NOT INSTITUTEL SERVICES -
NEEDS GROUP HOME SETTINGS TO PROVIDE INDIVIDUALS
Widow y + SELF ESTERM (OUER)

I AM NOT objected to Change on Out Backs PLEASE CANTINUE DEVELOPMENTAL DISABILITED
RESIDENTIAL HABILIAKE VITRANSPORTATION WALVER You All NEED To Look into the A mount of Prospect on Moderal Walvak JA-"Delmany Their DA is NOT All together Appropriates If the PA (Quality ASSURANCE) was bested on What You will, How you will, REcords Kept it would be worth wild. Most of HISTR REVIEWA based on policies & procesures. Not the care (delivered. I think MEDICAID is paying A Large Amount of Funding Heat is in Approponately being used For GA - This Funding Could be used on Direct care I AM NOT Saying that these should not be a DA System but I think what we have + ARE paying DELMARINA Could be obtained through Someone PLSE LESS EXPENSIONS, What will be own SAFequand To Allow is to continue quality COLE TO OUR Special NEEDS RESIDENTS ? They AND AGES 21-63 YEARS old with Vaxies Louds of physical + Mental Disabilities. THANKS For Coming TO TAMKOS AND Listening To the Community-



Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review.

Name: WOLT SCHORNIG DONOYOUR
Association: CAMWASTION FOR THE DITADVANAGED Address: 2408 FAIRBANKS DR.
Address: 2498 PAIRBANKS DR.
CLEBRUATED FL 33764 2812
(Please use the front and back of this sheet to provide your information.)
10 Allo ema



Reply with original e-mail message

From:	waltsc@webtv.net. (Walt & Georgia Schoenig)
То:	lisa.bacot@dot.state.fl.us
Cc:	
Subject:	Re: Medicaid Reform Public Hearings
I will attend the l	nearing in Tampa tomorrowmy comments are:

MEDICAID PUBLIC HEARING 2-11-05

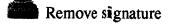
MORE THAN A YEAR AGO ACHA AND THE COMMISSION ON TRANSPORTATION FOR THE DISADVANTAGED BEGAN NEGOTIATIONS TO CENTRALIZE THE AUTHORITY FOR THE MEDICAID PROVISION THAT REQUIRES A RIDE TO NON-EMERGENCY MEDICAL SERVICES.

A CONTRACT WAS SIGNED WHEREAS THE COMMISSION WAS ACCOUNTABLE FOR THE SPECIFIC ANNUAL BUDGET AND WOULD ASSIGN TO THE COMMUNITY TRANSPORTATION COORDINATORS OR ANOTHER VENDOR FUNDS TO OPERATE THE SERVICE. ALL BILLS WOULD BE PAID VIA THE COMMISSION,

THE FORMER SERVICE WAS BROKERED BY THE DISTRICT ACHA OFFICES AND THEY NEGOTIATED THE RATES. SAVINGS ARE MADE VIA THE NEW SYSTEM.

I RECOMMEND THAT YOU CARVE OUT THIS SERVICE AND LET IT STAND ALONE.

WALT SCHOENIG
727 536 3477 2428 FAIRBANKS DE
CLEARWATER, FL. 33764 2812
TURN PASSION INTO PERSUASION





Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review.

Name:

Association: LI+LLINK HEALTH CHRE LVS (
Address: 409 BAYSHORF BLVI)
TAMPAT FZ 33606.
(Please use the front and back of this sheet to provide your information.)
A great percentage of our Transplant
Patients are on either straight Medicard
or Medically Needy Program Without
this program, these people will not
be able to get Medications and Consequently
Will lose their transplanted organ. Kilney
patients will go back on i Pulysis, which is
Very very expensive, but will subsequently i Die,

Other Transplant patients, Liver, Heart, etc have no other life systaining oftens, so will be given a death sentence. Without these programs, patients will be denied the chance of transplant, as without medication coverage, they will not even be able to be put on a Transplant List. Changes in Medicard will affect our most Vunuable atizens; the Elderly and disabled, the people that this great country, should be caring for I am totally disquoted that every year, this enomens worry is put again and again on these poor Prople:

Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review.

Name:	Laurie Shore
Association:	LifeLink Healthare Thortete
Address:	409 Bayshore BIND
	Trumpa, FL 33606
	ر المرابعة front and back of this sheet to provide your informa

tion.)

Transplant Center, as if the medicaed lose their t

he slegble to apply for frangplanto without the
opten of nedleard, which with ast in their
deaths. They will extres die from their predical
Conditions, committing Strucke due to rach of
option of transplant or loting their transplant
These patients deserve this option. They will
be inable to afferd the estranty high
medication costs without redical Transplant
with be left as any an option for the Very
sich, or very foot. We cannot allae this
in our society.
,



Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review.
Name: <u>br. bonno letersen</u>
Association: USF College of Nblic Health
Address: 13201 butle B bowns blue MC56
Tompo FL 33612
(Please use the front and back of this sheet to provide your information.)
Lurge you to
1. corefully examine the inderlying reasons for
the increase in expenditures - is it changes in
envollment potterns? benefits utilized? site of
core? costs per unit of service? woste?
2. consider Medicaid in its broadest context
Medicaid is a health care financing mechanism
that can only function efficiently in an -
·

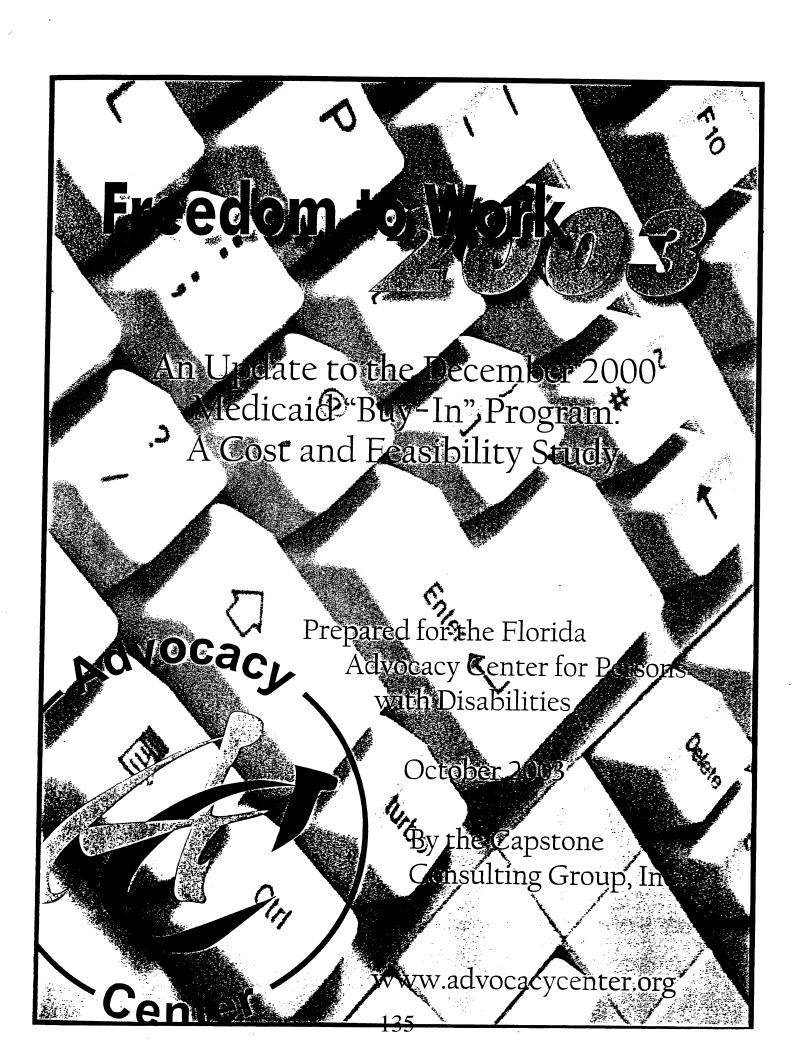
environment that provides access to quality cove and promotes apportunities for people obviously, the best way to reduce cost is to reduce the need for expensive cone through preventive interventions, quality primary core, disease management d low-cost afternatives to in-patient cone. As been of the USF college of Public Heaven I pleage the support of our towlth, who one expert in many of mese areas, to assist you in your important deliberations. The vitality of our state depends on the hearth of citizenny and the economy. I wish you much success. Thank you

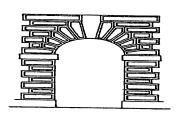
Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review.

Name: Barry Shalinsky
Association: Advocacy Center for Persons with Disabilities
Address: 1000 N. Ashley Dr., Suite 513
Tampa, FL 33602
(Please use the front and back of this sheet to provide your information.)
It is important that persons with all types of disabolities
have parity of coverage, including persons with mental
ollnesses and transactic train injuries.
V
Please consider adoption of Freedom to Work
Medicaid Buyin to encourage persons with disabilities
to werk. See attached.





The Capstone Consulting Group, Inc.

4220 Natural Bridge Road Tallahassee, Florida 32305 Phone: 850-421-6605

Fax: 850-421-8439

www.askcapstone.com

ACKNOWLEDGEMENTS

Our thanks to: Pat Brown from the Department of Children and Families, Office of Economic Self-Sufficiency; Tony Swinson and Fred Robeson from the Agency for Health Care Administration for their help in providing the data used for this report.

On a national level, thanks goes to: Melissa Wittman, National Consortium for Health Systems Development; Susan Daniels of Daniels and Associates; and Marie Strahan, National Ticket to Work and Work Incentives Advisory Panel.

Special thanks goes to the Advocacy Center for Persons with Disabilities for their leadership on this issue and to the Medicaid Buy-In Work Group who is keeping the focus on this critical health care access issue. Work Group participants include: Anne Swerlick and Dorene Barker, Florida Legal Services; Tone Vogt, Florida Development Disabilities Council, Inc.; Shelly Brantley, Department of Children and Families, Developmental Disabilities Program; Corinna Steiger, National MS Society of North Florida; Jesse Fry, Florida AIDS Action; Elizabeth Jennings, Gulfstream Goodwill; and Ellen Piekalkiewicz, Tara Hopper-Lozowick, Barry Shalinsky, Victor Panoff of the Advocacy Center.

TABLE OF CONTENTS

Executive Summary	4
Health Care Access for Individuals with Disabilities Who Work: A National Overview	7
Medicaid Buy In Design Consideration Checklist	13
The Florida Experience	19
SSI Related Programs - Financial Eligibility Standards, July 2003	23
The Ticket To Work and Work Incentives Improvement of 1999 (TWWIIA): The State Option for Expanding Medicaid Coverage for Individuals With Disabilities That Want To Work	25
A Program Design for Florida	26
Program Design Elements	27
Potentially Eligible Population	35
Fiscal Impact and Benefits	38
Literature Reviewed	41
Relevant Websites	43
Attachments	44
Attachment A	46
Attachment B	. 51
Attachment C	57
Attachment D	75
Attachment E	80

EXECUTIVE SUMMARY

Overview:

The Congress passed the Ticket to Work and Work Incentives Act (TWWIIA) 1999 to further expand the incentives available to persons with disabilities who want to work. Fear of losing health care benefits due to earned income is a major area of concern to individuals with disabilities.

In fact, Florida work groups studying this issue in both 2000 and in 2003 found that:

- ✓ There are persons with disabilities who could enter or re-enter the workforce, but who are reluctant to do so for fear of losing their Medicaid health care benefits.
- ✓ Health insurance is a major concern of persons with disabilities.
- ✓ Health insurance is not available to many disabled persons, even if they could afford it.
- ✓ Persons with disabilities have special needs that require extra resources in order to enter or re-enter the workforce.

Clearly, individuals with disability, if they lose their Medicaid due to increases in earnings, enter the ranks of the "uninsured" in Florida, but with added considerations due to their disability. These individuals must be able to maintain health care coverage or they cannot maintain the level of heath and physical stability needed to work.

Recognizing these conditions on a national level, the TWWIIA gives states the option to provide Medicaid coverage to persons with disabilities who work by creating two new <u>optional</u> Medicaid eligibility groups: the "Basic Coverage Group" and the "Medical Improvement Group." States are not, however, required to cover both groups. This study focuses on the Basic Coverage Group.

In 2000 at the request of the legislature, the Florida Agency for Health Care Administration (AHCA) commissioned the Capstone Consulting Group, Inc. to conduct a cost and feasibility study of the Ticket to Work and Work Incentives Act (TWIIA) Medicaid Buy-In option for Florida. This report the: Ticket to Work and Work Incentives Act: The Medicaid Buy-In Program, A Cost and Feasibility Study was completed in December 2000 and is available at the AHCA website.

This initial report reflected the work and recommendations of a Steering Committee comprised of state agency representatives, advocates and legislators. The study findings were based on community forums, a statewide survey of individuals who were identified as potential users of a buy-in type program, and national research.

Work towards the passage legislation that would create a Medicaid Buy-In program in Florida has continued since 2000. A bill has been introduced in each year's legislative

session. In 2001 a bill did pass and the Department of Children and Families (DCF) developed implementation policy. Due to the events of 9/11 and the resultant economic downturn in the state, the legislation was in effect only one quarter and was repealed effective July 1, 2002. Nineteen individuals were enrolled in this program for one quarter. A decision was made to stop enrollments prior to the official April 1 implementation date due to the uncertainty of future funding for the program.

In light of the need for a Medicaid Buy-In program in Florida a Work Group emerged in 2003 under the leadership of the Florida Advocacy Center for Persons with Disabilities. This work group includes: The Advocacy Center, the Florida Legal Services, the Florida Developmental Disabilities Council, Inc., the National MS Society of North Florida, Florida AIDS Action, and Gulfstream Goodwill.

Because of the rapid development of Buy-In programs in the nation, the work group decided to commission an update to the 2000 study and to review the Florida Buy-In design created by the original Steering Committee. There are now 25 states, many with multi-year experience involved in Medicaid Buy-In programs. In 2000 there were only nine.

The options afforded states under the TWWIIA include the ability to eliminate, or set its own income, asset, and resource limits for workers with disabilities that meet the SSA definition of disability.

Recommendations:

With respect to the income and asset eligibility criteria, the committee recommended the following standards:

Income Limits/Income Exclusions:

- Unearned Income Limit of 88% of the Federal Poverty Level (FPL)
- Exclude countable earned income up to 250% net of the federal poverty level (FPL)

Asset Limits:

- Exclude cash assets in the amount of \$8,000 for a single individual and \$9,000 for a couple.
- Exclude, any retirement account recognized by the Internal Revenue Service.
- Exclude a second vehicle for a couple.

Premiums:

• Participants in the buy-in would be charged a premium once their incomes reached the federal poverty level.

Participation with Employer- Sponsored Health Insurance:

 Medicaid could pay the premiums of an employersponsored health plan if it was in the best interest of the state and did not harm the Buy-In participant.

Required Workforce Participation:

• Individuals are required to be employed or engage in preparation for employment.

Protection If Individual Loses Workforce Connection due to Health or Involuntary Separation

 Individual will be allowed to remain in the Buy-In program for up to one-year premium free if they are forced to leave the workforce because of health or involuntary separation.

Costs and Benefits:

The ability to identify the number of persons who may be potentially eligible to participate in the buy-in program is the most difficult, complex, and variable part of this study. However, a figure of 1136 eligible participants is used in the study's projections to account for as many variables as possible.

Regardless of the parameters of eligibility, not everyone eligible to participate in the program will do so.

It is projected that this program will cost the state \$3,462544. The Federal government will supply the additional \$4,962162 of resource for full funding of this program. Families USA has identified that every Medicaid dollar spent in Florida generates \$2.82 in business growth, wages, and jobs. Additional wages and taxes generated by the increased earnings of these individuals will also have an economic impact. According to the Able Trust, for every dollar earned by an individual with a disability, \$.23 is generated in income back to the state.

In brief, the Work Group strongly feels that Floridians should be given the freedom to work without fear of risking their health due to lack of health care coverage.



Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review.

Name:	I Ch Cocas
Association:	
Address:	FUS E. Chelsenst
	Tampa FL 33603
(Please use the fr	ont and back of this sheet to provide your information.)
In	reed Medicad to pay for my
	ications to keep me alive
	10 amonth. Insurance Companys
	not cover me
	On Two



Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review.

Name:	Lynn Kingenberg, M.D.
Association:	Florida Rediation foriety (FPS) 80162 ST. G. All Childrens Hospital
Address:	801 6 D ST. Go-All Childrens Hospanl
	8t. Pole 33701
(Please use th	ne front and back of this sheet to provide your information.)

Florida Pediatric Society Florida Chapter of the American Academy of Pediatrics

Comments Regarding the Governor's Proposal to Change Medicaid

I am here to speak on behalf of the Florida Pediatric Society. Since its foundation in 1936, the Society has advocated for the needs of Florida's children, rich and poor alike. Florida Medicaid has been the target of much of our effort, because it is often the only resource for children whose families are among the poorest in Florida. For years, Florida Medicaid has failed to provide children with appropriate access to needed health care. Medicaid is THE health resource for thousands of poor children in Florida, and without it many of Florida's children would have no access to health care services. However, for years ongoing hassles (like having children mysteriously drop off of Medicaid without their parent's knowledge), punitive physician audits, and other idiocy (like the seriously ill child who depends on Medicaid transportation, yet Medicaid will not pay for more than one destination on a given day – forget it if the child needs to go to the lab, or x-ray. or the pharmacy!) have prevented needy children from accessing appropriate services. Medicaid has never paid physicians what it costs to provide care, yet the numbers of Medicaid patients is steadily increasing. The token increases in physician reimbursement over the last 10 years have not even kept up with inflation, yet physician payments constitute only 4% of Medicaid expenditures. Medicaid HMOs make physicians and patients jump through multiple hoops to get needed services, yet we know that it costs less to provide care to Medicaid children under MediPass (which is fee-for-service in Florida) than under Medicaid HMOs.

The Governor's proposal for changing Medicaid does not offer any relief in any of these areas. In fact, the Governor's proposal seems to add several new roadblocks. Medicaid has been broken for years, and will only get worse under the Governor's proposal. The pediatricians of Florida are particularly concerned about 4 areas of the proposal to change Medicaid.

- 1. **EPSDT.** The universally accepted standard for child health care in this country is the periodicity schedule developed by the American Academy of Pediatrics. You know, the scheduled check-ups and shots for your kids, making sure everything is ok, not unlike mammograms or prostate screening in adults. In Florida, (Florida Statutes 627.6579 and 641.31(30)(b)), known as the Child Health Assurance Act, require that all children insured by commercial plans receive these services. Under Medicaid, these same services are known as EPSDT (Early Periodic Screening Diagnosis and Treatment), now called Child Health Checkup in Florida. EPSDT services are mandated by the Feds under Title XIX of the Social Security Act, and are currently the framework for routine medical care to Florida's Medicaid children. We are concerned that the Governor's proposal does not speak to EPSDT services. All of Florida's children deserve the EPSDT benefit package, and anything else would be unconscionable.
- 2. CMS. We are unclear where Children's Medical Services (CMS), Florida's premiere

program for children with special health care needs, fits into the governor's proposal. CMS is a complex program with an ever-changing patient population. Children continually move in and out of CMS, depending on their changing health care needs. CMS depends on fee-for-service Medicaid for funding, which seems to disappear under the governor's proposal. We cannot imagine that Florida intends to destroy this premier program, which includes both specialty and primary care networks. CMS has been a nationally recognized model, demonstrating the benefits of a public-private partnership to provide primary and specialty services to Florida's children with special health care needs, and other indigent children. We encourage that you assure that this essential program continues intact.

- 3. <u>Co-Payments.</u> The governor's proposal speaks to allowing participants to "...contribute to the cost of their care...". This amounts to a co-payment, and is forbidden for children under the Federal Medicaid statute. Additionally, programs for the poor that impose cost sharing serve to reduce the use of necessary services, leading to a potential increase in the severity of illness, which in the long run actually increases the overall cost of care. This approach will simply shift the cost from the current federal-state shared responsibility, to the private sector. The private sector is already insufficiently compensated for the services rendered to Medicaid recipients, and such action will simply serve to drive more private providers from participating in the Medicaid program. We encourage you to reconsider this short-sighted approach.
- 4. Managed Care. Increased Utilization of Managed Care will further erode available services for Florida's children. Adding more managed care "middle men", who must send dollars home to their shareholders, will of necessity make fewer dollars available for the care of Florida's children. In this time of budget short falls, it is incomprehensible that Florida would propose to cap the available per-patient dollars, impose more managed care, and thereby further limit the services available to any individual patient. As noted previously, we already know that the care for Medicaid children is cheaper under MediPass (or fee-for-service), than it is under Medicaid HMOs. Medicaid officials describing the Governor's proposal have stated that providers prefer Medicaid HMOs not true! The recent issue of Florida Medical Business touts the popularity of MediPass "...where 3,002 providers rendered care to more than 702,000 beneficiaries last year..."

In summary, although the Governor's proposal is called "reform", the Florida Pediatric Society has grave concerns that this plan will actually perpetuate previously unresolved problems with Florida Medicaid, and will add a whole new series of problems that will assure that fewer children get appropriate health care, and that will decrease the availability of needed care to Florida's poor children.

Respectfully Submitted:





The Florida Legislature Senate Select Committee on Medicaid Reform House Select Committee on Medicaid Modernization **Public Hearing Comment Form**

Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review.

Name: Cynoii GRATE
Name: (.y. N. Dii GRATE Association: Colis (Caregivens Organized for Physically Impaired Students) Address: POBOL 281
Address: $POBN291$
Address: <u>POBOL281</u> Nichols, JR 33863-0281
(Please use the front and back of this sheet to provide your information.)
I & my son Adam spoke today. I want
to give the panel Deveral other examples of
medicad funding waste in Florida. adam
Spoke sport medicaid funds paying \$9000/Cice
(a case = 3 pkgs of diapers) that sell in ANY store
for 1 to 1 Dkg!) I requested that Yarretts
Medical Supply in Winter Haven send me paper
work as proof of price gouging - I've Been waiting
72 yrs. Other medical Supply providers Refuse
146

to fell we consumers the Price of what Medicaid parp for Supplies - Why the Secrets? Listed below are several ex: of medicaid funding waste we have experienced -1. a We Brake tightening (3 min jon) was Billed to redicard as a We annual maintainence of \$25000 2. Dr. visit (PCP) that just are to Be seen to Set Refills scripts (Regard to see & Paya Dr for Hat = stupiel -Sen & Smin are Billed to Medicaid as extended visits or complete Shipiculs. 3. DC 7(DDP) & (MS agencies get funds that are spent On their Salay increases, Newdeske improved phone Children Cisabilities to live independing in the Home -4. A pill ONE for Alam Medicaid gay 44000 /pill Twice a day!!! In a hospital Twant to Know @ x my son's medicaed is billed + spending Note: Please see Page 2

Page 2 from Ceptai Grate 2-11-05 folk Co Klease Know: DMy son Adam Alguired a 5th & final surgery on this face By DR. MuTez Husul in Tampa. It was set up & the day before, modicaid Alfused to pay DR. Habals Surgery fee. Dr. Habal was forced to refuse medicard Participation Because of Non-payment for years & years. adam's Hospital Billswould rel Be paid by nedicaid But after several years of waiting forlidams skelletuil naturity - He Now can't have the needed surgery. Dou Da Regislators Refuse medicaid herds to Pay for Needed Awning Over our Kids Wheelchair Ramps. Leavingour Kids Prisoners in Their Homes. If nedicaid cost WASTES Price gargine were Stopped nedicaid would have millions // See.

37

FOR IMMEDIATE RELEASE January 27, 2005

Rostadole

Senate President Tom Lee and House Speaker Allan-Bense Announce Joint Regional Public Hearings on Medicaid Reform

Tallahassee, Fla. – In preparation for upcoming legislative action on Medicaid, the Senate and House today announced their intention to conduct joint public hearings on Medicaid Reform. These regional hearings will take place throughout Florida beginning Friday, February 11 and concluding on Monday, March 14.

The purpose of the hearings is to gather information from providers and Medicaid recipients who may be affected by changes to Florida's Medicaid program and to collect innovative ideas on ways to reduce the rapid growth in Medicaid costs while continuing to provide needed services to Florida's elderly and disabled. The Committees will also solicit input on the Governor's proposal to reform Medicaid.

Today's information follows recent announcements by the Senate President and the House Speaker of the formation of a Senate Select Committee on Medicaid Reform and a House Select Committee on Medicaid Reform. These committees have been charged with the responsibility of gathering information and making recommendations to their respective chambers for changes to the state's Medicaid program. Attached is a list of the membership of the two select committees.

The dates and regional location of each public hearing are listed below, but are subject to change. Please refer to the published calendars for the House and Senate which will reflect the most up-to-date information, which can be accessed on the legislative websites: www.flsenate.gov or www.myfloridahouse.gov.

Members of the Senate Select Committee on Medicaid Reform

★ Sen. Lisa Carlton (R-Sarasota), Chair

Sen. Burt Saunders (R-Naples)

Sen. Mike Haridopolos (R-Melbourne)

Sen. Walter Campbell (D-Ft. Lauderdale)

Sen. Ron Klein (D-Boca Raton)

Sen. Jeffery Atwater (R-Palm Beach), Vice Chair

Sen. Durell Peaden (R-Crestview)

Sen. Alex Villalobos (R-Miami)

Sen. Mandy Dawson (D-Ft. Lauderdale)

Members of the House Select Committee on Medicaid Reform

Rep. Joe Negron (R-Stuart), Co-Chair

Rep. Joyce Cusack (D-DeLand)

Rep. Andy Gardiner (R-Orlando)

Rep. Marco Rubio (R-West Miami)

Rep. Eleanor Sobel (D-Hollywood)

Rep. Holly Benson (R-Pensacola), Co-Chair

Rep. Anne Gannon (D- Delray Beach)

Rep. Mark Mahon (R-Jacksonville)

Rep. Aaron Bean (R-Fernandina Beach)

Rep. Paige Kreegel (R-Punta Gwoda)
941-575-5820 (Jonathan Strong leg. airle)
850-488-1175 (Talla hassee, FI)



Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review.

Name: Stephanie Mitchell-Madden
Association: Community Health Centers of Pinellas (writing as 2 Address: 10200 N. Armenia Ave. #301 Private citizen
Address: 10200 N. Armenia Ave. #301 Private citizen
Tampa, FL 33/e/2 not employee
(Please use the front and back of this sheet to provide your information.)
1 am writing this narrative as a private citizen
though lam employed at a Community Health
Center and see many folks who may be affected
by changes in the medical d system.
lam young, in my twenties, and I am
one of the few people my age who is insured,
let alone concerned about medical insurance.
Most of the young people I know commot

afford the skyocketing costs of healthcare and pray then don't get very sick. Most of time, they only become insured when then become pregnant and become eligible for medicaid. The medicaid program has many women I know be able to have a healthy pregnancy without declaving bankrupton. ware you to keep the "optional" benefit available for young women and children the future of our state. Lack of healthcare is not going to keep women from becoming pregnant (comprehensive sex education is the answer, but that's another topic), but it women from getting prenatal Almost half of all pregnancies are covered by Medicaid in Florida and I wroze you to is one of the beast costly benefits compared to prescription drugs or elderly care. Thank you for your consideration.



Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review.

The passe reality of the control will be made available to the Continuite members for their review.
Name: Kon Linguas
Association: Skrewy Hospital
Address: 12502 N. Pine Di.
Tampa fla 336/2 rgingras @ Shrinenet.org
(Please use the front and back of this sheet to provide your information.) b demase shinenet org
forty perent of our gatures are joint
melicand Shriner Jounts Curretty we
und together with medicaid on voices
reguling transpurfation, medication.
All gou services are free to the public
Imedicail. Du Concerns include
being included in the grovers of change. We are
by provide an estimated 54 million dollars worth of
Wellant Care, perving 11,683 Spediatric patients in This Fate,

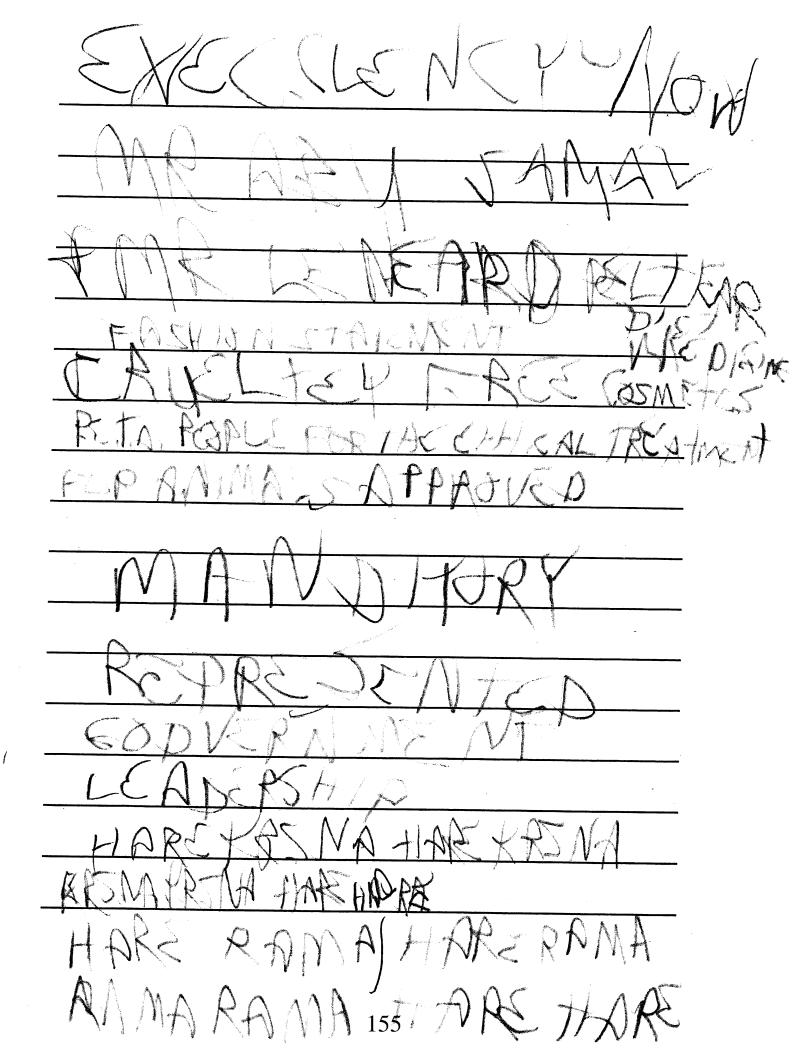
We impact the	Community	by emplay	302 person	7.
We impact the Dur paypoll = 12,3	09 11 1	1.04	0	
Our payou - 12,3	81000 gr 6	1007		
				<u> </u>
	·			
			•	
	· · · · · · · · · · · · · · · · · · ·			
· · · · · · · · · · · · · · · · · · ·				
	· · · · · · · · · · · · · · · · · · ·			
			•	



Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review. Name: Association: Address: (Please use the front and back of this sheet to provide your information.)





Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review.

daring the publi	c hearings. All forms will be made available to the Committee Members for their review.
Name:	Elizabeth Rustr
Association:	Suncoast Health Council , Inc. / Health Council of West
	9455 Koger Boulevard - Suite 104 Central Florida, Inc.
	St. Peters Wig, FL 3370>
	e front and back of this sheet to provide your information.) .: Each individual should have access to basic
nical cal	Care, regardless of their ability to pay.
We Believe	.: Health care should be the joint responsibility of
the individ	val and society, including for profit enterprises that
reap 519	nificant benefit when health care services are.
whired be	y particularly vulverable residents.
SUGALSTIC	n= IF/as the formolary for prescription drugs
15 reduced	for Medicard recipients, consider fonding the
parant a	of a state-write network of compassionate drug soistance programs to promote access to free ogh the pharmace 156 cal nanofoduring industry.

The Soncount Health Council convently administers
compassionate use programs in finellas and Pasio com
which scarre \$18.11 in free prescription drugs for every-
#1 used to provide program services.
- Comment of the contract of t



Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review.

Alexandra Furnari

Name:

Association: Hillsborough CARES member
Address: C/6 CBHC 1002 E. Palm Ave Tpa 33605
(Please use the front and back of this sheet to provide your information.)
I hope that increased focus on prevention will
be incorporated into your Legislative proposal.
be incorporated into your Legislative proposal. Aunling for ALF's, Getting nhome care and homervices to keep some
persons out of mursing homes is currently
very difficult. Maintaing prevention care
for pregnant women and children can
reduce future costs. Instead of an HMO
and a ASO [Adminstrature Service Organization]

Could be an excellent alternative. Ix
families had abudget Through The ASO
Case manager, They could negotiate with
providers of medical services & therapy,
and choose The best providers for them.
Family choice is important to maintain.
Given that medicaid federal funds flow to the
State we need to maintain as much of Those
funds as possible. Cutting book on care has
a considerable trancad impact on The
economy of the state. Health care 75 a
basic right and as pouch willing to pay more
taxes to make sure we have a strong health
Care system. Maintaining open access to medications
is important particularly for persons with mental
illness.



Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review.

Name:	Doo Jay 1 March of	Hellrung	
Association:			
Address:	1831 NW	13 St Sock	3
	Gans villa	13 St Soch Pa 32609	
(Please use th		sheet to provide your infor	
	The day Ball, unp The day Ball, unp	March of Dimes Saving babies, together	
		Florida Chapter 1831 NW 13th Street, Suite 3 Gainesville, FL 32609 Telephone (352) 378-9522 (352) 372-4093 Fax (352) 377-5918 Email: djhellrung@hotmail.com www.marchofdimes.com	

Medicaid Modernization Proposal -Gov. Jeb Bush (R-FL) MOD Talking Points

Access to health care coverage is central to the March of Dimes mission to improve the health of babies by preventing birth defects and infant mortality. The National Governor's Association reported that in 2000, Medicaid financed 44 percent of all births in Florida. Nationally, it funds 40 percent of hospitalizations for children born too soon, too small, or with birth defects.

Medicaid was designed to be a flexible, counter-cyclical program, meaning that it responds to rises in poverty, loss of jobs, loss of private insurance, and other causes of uninsurance. Currently, the federal government shoulders about 59 percent of the cost of Florida's Medicaid program, with the state picking up the other 41 percent. The governor's Medicaid reform proposal will cap annual Medicaid spending, meaning that Florida can no longer be flexible to need arising from unforeseen events, such as hurricanes and tornadoes. If Florida's Medicaid spending is fixed, as in the current modernization proposal, the state would receive a low amount of funding per recipient, making it difficult or impossible to cover a host of badly needed services for pregnant women, infants, and children.

Without the guarantee of coverage, many of Florida's pregnant women and children will lose access to needed health care services. Uninsurance rates will inevitably rise, exposing the health of pregnant women, infants, and children to higher risk.

- Prenatal care is crucial to identifying problems early and providing treatment that may help improve the health of both the mother and baby. Twenty-nine percent of uninsured pregnant women have no usual source of care, while 15 percent will have no prenatal visits at all.¹
- Children who lack health care coverage tend to receive care late in the development of a health condition, if they even receive care at all. This places an enormous burden on hospitals, who are likely to see these children in an emergency room for treatment of a condition that could have been contained with timely outpatient care.²
- Uninsured children with special health care needs suffer the most. They are more likely than insured children to be without a usual source of care. Most likely, they will have gone at least 12 months without seeing a doctor, and are more likely to find medical, dental, vision, and mental health care, as well as prescription drugs, out of reach.

The modernization proposal does not offer any guarantee that pregnant women, infants, and children with special health care needs will have access to services they need. Under the governor's proposal, insurance providers – not federal law – will dictate the amount, scope, and duration of services available to pregnant women and children. Further, the proposal offers no safeguards against "cherry-picking," where individual market insurers can choose to cover only those patients who are relatively healthy. Sick children, or high-risk pregnant women, will undoubtedly have a hard time finding quality affordable health coverage.

¹ Bernstein, Amy B. 1999. Insurance Status and the Use of Health Services by Pregnant Women. Washington DC: March of Dimes.

² Health Insurance is a Family Matter. 2002. Committee on the Consequences of Uninsurance, Board on Health Care Services, Institute of Medicine of the National Academies. Washington DC: National Academies Press.

- Pregnant women may encounter difficulty finding affordable, comprehensive health care with maternity benefits. The modernization proposal amounts to a health care "voucher" with which patients can purchase private health insurance. Unfortunately for pregnant women, health care services related to pregnancy and childbirth are typically absent from health insurance policies sold in the individual market. Where it is available, it is very expensive and quite limited. Coverage for women who are already pregnant (which would be all women in Medicaid who become eligible solely because of their pregnancy status) is simply not available at any price. Even state high-risk pools usually consider pregnancy a pre-existing condition and exclude maternity care from coverage. Any Medicaid reform plan must guarantee that pregnant women will be able to access prenatal and maternity care.
- Children with birth defects and other special health care needs could be left without access to the care they need. Under federal law, every child identified as having a health care condition through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is guaranteed all medically necessary treatment services for that condition, regardless of whether or not the state Medicaid plan covers those services for other populations. This benefit is a lifeline for the sickest children in Medicaid, who would likely have difficulty finding affordable individual market plans that offer such comprehensive screening, diagnostic, and treatment services. Even the catastrophic coverage allowance in the proposal comes with a limit. At what point would a truly sick child exhaust their maximum benefit allowance, and what is to become of them if they reach this point? The most vulnerable may lose their right to all medically necessary services.

³ Neuschler, Ed, Institute for Health Policy Solutions. 2004. *Policy Brief on Tax Credits for the Uninsured and Maternity Care.* Prepared for the March of Dimes.



Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review.

Name:	John Bracken, Executive Wirector
Associatio	on: Suncoset Mental Health Center Inc
Address:	88145. U.S dwg #1 ste 8-4
	Ft. Pierce, Florida 34983

(Please use the front and back of this sheet to provide your information.)

As I tay and operate A medium size mental health center that

provide emotional and psychological support and treatment for Children

in the Treatme Coast, I am faired with issues that I know we all

face: increase cost and newtralized or decreased income. I try to

provide the type of case that improve lines, we cut back overhead,

where reduce solonics, Always writing to the last to reduce core. I

believe that the current thus program that will take effect

in our vistrict in July Job will Fragily cause a reduction

in the type and quality of Cone. Managed come will Reduce
V
Our funds by a possible 30% just to pay for the managed One exity, When I became a professional in 1982 the
Motto was "Day more for les" Now over twenty year
later its still the same I agree that medicaid needs
to be spert non officiants however, taking so much
off the top just to pay for printe Almhistation. Have
the State Administer the HMO At its current Budget
Jewel. The state is contantly Ashing me to Do more
with less - the State Should do the Same



Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review.

JOHN LAGUES, Ph.D.

12512 Ray - R D

Association: NORTHSIDE MONTAL HEALTH CTR

Name:

Address: TESTE PICKE DI VOLLAS DEVV
TAMPA FL 33612
(Please use the front and back of this sheet to provide your information.)
In the area of mental health clients, are dependent
upm Medicaid & pay of treatment services and medicistions.
There are the Denoisly of Prisistently Mentally Ill Adult,
at perinsly Emotioned Distribed child, With attacks
" Medicaid these most It risk clients will become
muchino of monetary restrictions on care al needed moderation,
Complete with the cut, it the Hellsbrough Coul Health Plan,
many will be without any bealth w mental health average,

The Commind Mental Health systems is currently underfulal X DCF for warent serves I relies hamil a Medicant ing to defray elect & operatual cost sympant inpar treatment up & obdress Medicail needs 6 Enrolling families is lien of identicals, on Madicant Somethe melinet meress paperole il felling wood (2) Bundling Kedward billing - amonthy every sungle I required valedaded



Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review.

dishonest marketing practice). Il know this was a problem early on in the local warm for mental health seemen in the Healsborsugh) area in 1996, and continue Loday to some degue, Hax really 3000 your found consumer have greatly limit the capacity to navigate Tier signer," etc. The most needy and The most descring of our disabled population may well be unacle to participate in the Current difficulties experienced within the managed care funding entities are many. Medications needed to keep Chronic One persistent flagle our y haspitale and institutions ofthe require prior authorisation for more advanced Phipierous should be allowed to gresnike these Gredel medications wishout filling ver als paperwark and making numerous phone call to people of our state; do not privatize the Charle Medicail septem



Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review.

	-	
Name:	Robert Wirengard	· Let me know if
Association:	Human Race	you want to sait to do Hunga right
Address:	6234 N Falkenburg Rs	
	Fair Share FL 33610	813-758-1595

(Please use the front and back of this sheet to provide your information.)

"Privatization is not understood and quartey miss applied by Legislators. Dr. Milton Friedman - "father Bluivatization wrote to me when "money is appent by the individual",, "There is real Privatization"; Neither goo't mor a corporation, both 3rd parties, is the private spender. Friedman wrote elsewhere, "No one can append as wisely or fugally for some one else, as the one can for one self,"

We mud to give the funds for health care directly to private eitizen patients to spend

Median fisted this they your ago, with disabled patients. costs were reduced, because good was not involved with buying or directing are and partients, They "concluded" were "happier". It works this way, If a potient is pusciful to get a wheel chain, Then the patient gets the going rate cost of one, to spend them selves. They could be the going rate one, or lung a used one pucheps, and save "money profit for Themselver; and, if they wanted a fancier one - perhaps with new view minors - then they had to pay for The extra Themselves, Those who profit by buying generics drive down The going nate and, the more who do so, the more the Brand Mediciner are losing busines, have to reduce given to get patients, It the first sime our market/people and vive given down and that we eliminate 3rd party costs that really are waster", costing us close to \$300 billion pergen according to a 2004 Haward Alley [Doctor & staff having to spend time on good/sneurance to payer work of for approval of proceeding or patient cligibility are eliminales 7 go her a patient can pay the dor for



Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review.

during the public	hearings. All forms will be	made available to the C	committee members for their rev	iew.
Name:	DIDNE SLAYBALK	H, SR PLANNER		
Association:	POLK COUNTY TRANS		COUNTY CTC	
Address:	DRAWPR HS09, PO			
-	BARTOW, FL 338	31-9005		
(Please use the	e front and back of this sl	heet to provide your in	formation.)	
POLK COUNTY	y is the designa	ted CTC-Como	writy TRANSPORTATION	
	J		forts of Medicaid N	SeT
	, .	_		
SERVICE S	FOR THE FLORIDA	Commission for y	the TRANSportation Disade	<u>urtag</u> as
- Speak	ATTACHED.		•	
		_		
		Superior Sup	Polk County Board of County Commissioners	
		POLK	DIANE SLAYBAUGH Senior Planner Transit Services Division	_
		Phone: (863) 534-536 Fax: (863) 534-042 Suncom: (863) 519-536	Drawer HS09, P.O. Box 9005	

Email: dianeslaybaugh@polk-county.net

I am hear today to urge you to exempt Medicaid NET (non-emergency transportation) services from Medicaid Reform. Last year, Medicaid entered into an agreement with the Florida Commission for the Transportation Disadvantaged, for the provision of transportation services. This move brought about credibility and accountability to the transport of Florida's most vulnerable citizens – the elderly and disabled, and ensures through our coordinated transportation system, that they receive critical, lifesustaining, medical care. Through Florida's coordinated system, which I might add, has been recognized nationwide by the federal government, as a model for other states, Medicaid NET services are currently operated through the CTC's (community transportation coordinators), which in most cases are comprised of county governments. As an example, Polk County Board of County Commissioners, serves as the Community Transportation Coordinator for our County.

To change this current structure, puts our most vulnerable citizens at risk, either to lose these critical, life-sustaining services, or to have the HMO's negotiate transportation with private, for-profit vendors, who don't have any standards to ensure the safety and security of the disabled and frail.

Therefore, I am here today to urge you to exempt Medicaid non-emergency transportation services from Medicaid Reform. Thank You.



Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review.

Name:	Edward Quill		
Association:	Volunteers of America of Florida		
Address:	605 S. Boulevard		
	Tampa FL 33606		

(Please use the front and back of this sheet to provide your information.)

A have spent 31 + years working with the elderly, homeless, honeless veterans and the seriously and persistently mentally ill all of whon are low income. These populations of incliniously are (especially the seriously and persistently mentallyill) in frequent need of medical intervention. If these services are put out to bid and consequently are provided by

HMO's whose profit is dependent on seeing individuals less the greatity of these people's lives will deminish It is therefore necessary to "carve out" services for these enclividualy in order to preserve the quality of core, The impact of this proposal willalso be falt by those elderly who reside in HUD bused 202 programs and are loss income. Coordination of services will be more defficult in a one providersysten where there is the pretense of choice lent with fewer service providers The field. Florida's most vulnerable cutizens will have less abulity to access services be cause many aervice providers will fall by the wayside without the potential for medicaid reinbursement for services undered.



Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review.

Becki Forsell

Association: VES! of America United, Inc. /Hillsborough Address: PO Box 341104
Address: PO Box 341104 Co. Grasstooff
Tampa, FL 33694 FILC
(Please use the front and back of this sheet to provide your information.)
This is a very important issue and
although some consumers with disabilitie
were able to attend today, but many
others were not able to attend due
to lack of announcement regarding
the availability of accomodations.
Ham visually impaired and had
Someone else read and consplete

This form since it was not provided in large print format. Since I am part of a new non profit organization and chair of the Grassroots, I understand Title 11 of the ADA requires public forums to provide accomodations. No sign larguage enterpreter was available, no closed caption, for the hearing impaired, no large prist forms for public comment and limited wheel chair accomodations. The location of itsday meeting was not accessible to all those that Use public transportation and from regions outside Jampa.

ADA INFORMATION SERVICES Revised August 2002

This list contains the telephone numbers and Internet addresses of federal agencies and other organizations that provide information about the Americans with Disabilities Act (ADA) and informal guidance in understanding and complying with different provisions of the ADA.

U.S. Department of Justice - Civil Rights Division, Disability Rights Section: The Department of Justice offers technical assistance on the ADA Standards for Accessible Design and other ADA provisions applying to businesses, non-profit service agencies, and state and local government programs; also provides information on how to file ADA complaints.

ADA Information Line for publications, questions, and referrals: 800-514-0301 (voice) 800-514-0383 (TTY)

Internet address (ADA Home Page)
www.ada.gov or www.usdoj.gov/crt/ada/adahom1.htm

Equal Employment Opportunity Commission:

Offers technical assistance on the ADA provisions applying to employment; also provides information on how to file ADA complaints.

Employment – questions: 800-669-4000 (voice); 800-669-6820 (TTY)

Employment – publications: 800-669-3362 (voice); 800-800-3302 (TTY)

Internet address www.eeoc.gov

Department of Transportation, Federal Transit Administration:

ADA Assistance Line for regulations and complaints

888-446-4511(voice); TTY: use relay service

Internet address www.fta.dot.gov/office/civ.htm

E-mail address ada.assistance@fta.dot.gov

Federal Communications Commission:

Offers technical assistance on the ADA's telephone relay service (TRS) requirements.

TRS Publications and questions: 888-225-5322 (voice) 888-835-5322 (TTY)

Internet address www.fcc.gov/cgb/dro

Office of Compliance:

Offers technical assistance on accessibility laws applying to Congressional offices and services.

Congressional accessibility 202-724-9292 (voice) 202-426-1665 (TTY)

Access Board (or U.S. Architectural and Transportation Barriers Compliance Board):

Offers technical assistance on the ADA Accessibility Guidelines.

Publications and questions 800-872-2253 (voice) 800-993-2822 (TTY)

Internet address www.access-board.gov

Internal Revenue Service:

Provides information about tax code provisions including tax credits (section 44) and deductions (section 190) that can assist businesses in complying with the ADA.

Tax code - information 800-829-1040 (voice) 800-829-4059 (TTY) Tax code - legal questions 202-622-3110 (voice) TTY: use relay service

To order Publications 535 and 334 800-829-3676 (voice) 800-829-4059 (TTY)

Internet address www.irs.gov

Department of Education:

Funds ten regional centers to provide technical assistance on the ADA. These are know as the Disability & Business Technical Assistance Centers. 800-949-4232 (voice/TTY)

Internet address www.adata.org

Job Accommodation Network (JAN):

Funded by the Department of Labor to provide advice on accommodating employees with disabilities.

Job Accommodation Network 800-526-7234 (voice/TTY)

Internet address www.jan.wvu.edu

Project ACTION:

Funded by the Department of Transportation to provide information about making transportation accessible.

Transportation information and publications 800-659-6428 (voice); TTY: use relay service or 202-347-3066 (voice) 202-347-7385 (TTY)

Internet address www.projectaction.org

OTHER LAWS OF INTEREST

Other federal laws prohibit discrimination and provide equal opportunity for people with disabilities in housing, air transportation, and access to Federal facilities, post offices and electronic information. The telephone numbers for obtaining assistance in understanding these laws are listed here.

Fair Housing Act, for questions or publications, call Department of Housing and Urban Development:

Fair Housing Accessibility Questions 202-708-2333 (voice) 202-401-1247 (TTY)

Fair Housing Publications 800-767-7468 (voice) TTY: use relay service

Internet address www.hud.gov/offices/fheo

Air Carrier Access Act, for questions pertaining to air transportation, call Department of Transportation:

Aviation Consumer Protection Division 866-266-1368 (voice) 866-754-4368 (TTY)

Internet address www.dot.gov/airconsumer

Section 508 of the Rehabilitation Act: for questions pertaining to the accessibility of Federal electronic information and technology, call the Access Board listed on page one.

Architectural Barriers Act: for questions pertaining to access to Federal facilities and post offices, call the Access Board, listed on page one.

LOCAL DISABILITY RESOURCES:

- Centers for Independent Living (13 centers in Florida)
- Paralyzed Veterans Association Chapters
- Local chapters of the Federation of the Blind
- Local Deaf Service Organizations
- Community Alliances for Citizens with Disabilities

The Council for Disability Rights

The Americans with Disabilities Act: Frequently Asked Questions

GENERAL QUESTIONS

What is the ADA?

The ADA is a federal civil rights law for people with disabilities, comparable to civil rights law passed in the 1960s for other minorities. It covers employment, state and local government services, public accommodations, and telecommunications for the deaf.

Why do we need it?

43 million Americans have physical or mental disabilities. Too often they are excluded from the mainstream of American life by attitudes and inaccessible environments. 67 percent of all people with disabilities are unemployed, even among college graduates. The ADA benefits all of us. Each of us has a 20 percent chance of becoming a person with a disability and a 50 percent chance of having a family member with a disability.

Who does the ADA cover?

All people with disabilities, visible and hidden, including:

- a person with a physical or mental impairment that substantially limits one or more major life functions (eating, breathing, caring for oneself, working, walking, etc.), OR
- a person with a record of such an impairment (even if that record is inaccurate), OR
- a person who is regarded as having such an impairment.

Some people are explicitly excluded from coverage, including:

- current users of illegal drugs (but those with a history of drug or alcohol abuse are covered, and an employer may continue to conduct drug tests on employees for illegal drugs.)
- those with "sexual behavior disorders" such as transvestitism or transsexualism, AND
- those who have the conditions of compulsive gambling, kleptomania, or pyromania.

What does the ADA not cover?

Housing except for hotels and other temporary housing (see the Fair Housing Act Amendments), buildings with primarily religious or private functions.

What about state and local laws providing rights to people with disabilities? If the state and local laws have stricter requirements, they still apply. For example, Illinois has stricter building requirements and does not have exemptions for religious entities.

If you have a family member or friend with a disability, are you covered? The ADA prohibits discrimination against a person who is "associated with a person with a disability." Thus, it would be illegal, for example, for a restaurant to refuse to serve a non-disabled person just because that person was with a person with a disability.

TITLE I: EMPLOYMENT

What employers are covered by the ADA?

Employers with 15 or more full or part-time employees are subject to the provisions of the ADA. Employment agencies, labor unions, and agencies providing fringe benefits or training programs are also covered.

What employees are covered by the ADA?

In general, the ADA prohibits discrimination against a qualified person with a disability. There are no affirmative action requirements in the ADA. An employer can still hire the most qualified person for the job as long as the disability is not used to disqualify a person.

A "qualified person with a disability" is one who is able to perform the essential functions of a job with or without a reasonable accommodation.

The "essential functions" of a job include those job tasks which are fundamental to the position, rather than marginal. For example, an essential function for a receptionist is to greet and direct visitors, not to hang coats. Employers should revise job descriptions to reflect the essential functions and approximate time spent on each task.

"Reasonable accommodation" is defined by the ADA by example and must be determined on a case-by-case basis. Examples in the statute include:

- * making facilities physically accessible;
- * job restructuring;
- * part-time or modified work schedules;
- * reassignments to a vacant job;
- * acquisition or modification of equipment or devices;
- * adjustment or modification of examinations, training materials or policies;
- * providing qualified readers or interpreters; and
- * other similar accommodations

Reasonable accommodations might include, for example, allowing an employee to nap on the job after a seizure or permitting a clerical worker to use the accessible executive bathroom.

How does an employer know if an accommodation is needed and which accommodation to offer?

It is the applicant's or employee's responsibility to request an accommodation. Employers should discuss the need for accommodation with the applicant or employee and investigate possible accommodations with groups serving people with disabilities and the Federal Job Accommodation Network. An employer is not required to provide the most expensive accommodation or the accommodation that the employee prefers, but it must allow the employee do his job.

Are there any limits on the amount of money an employer is required to spend on "reasonable accommodations"?

Accommodations are not reasonable if to provide the accommodation would result in undue financial or administrative burden. The ADA looks to the budget of an entire entity for financial burden; a fundamental change in a program is an administrative burden.

fundamental change in a program is an administrative burden.

Thus if an applicant who had learning disabilities, including short-term memory deficits, would need a full-time partner to be able to safely administer pesticides or herbicides, and in that position an employee traditionally worked alone, an employer could argue that to provide the accommodation would be both an undue financial and administrative burden. However, if the applicant only needed someone to read the directions once and then could safely complete the tasks, the defense of undue burdens would not be successful.

Can an employer have job standards without discriminating against people with disabilities?

An employer must assure that qualification standards are job-related and consistent with business necessity. Qualification standards, employment tests and other job-selection criteria must be analyzed to assure that qualified employees with disabilities are not screened out, whether intentionally or not, unless the criteria is essential for the safe and adequate performance of the essential elements of the job.

For example, to require a person to demonstrate the ability to pick up weights of 25 pounds or more would only be allowed if the employer can show that lifting such weights are basic elements of the job and that the tasks cannot be assigned to another employee or otherwise accommodated. Employers should match any employment requirement against the job description which defines the essential elements of the job. An employer may ask any applicant how he would accomplish certain job tasks (e.g., asking an applicant with visual impairments about word processing; ask an employee who has been on medical leave due to severe asthma how he would be able to complete his landscaping assignments).

Can an employer ask about the disability or require an applicant to take a medical examination?

An employer must eliminate pre-employment medical tests or inquiries. An employer cannot require any medical tests, or ask the employee or his references about medical or worker's compensation history, or ask even general questions about an applicant's health until after a job or promotion is offered. Post-employment medical examinations are only allowed if an offer has been made and all employees in the same or similar positions are required to take the test and the results of the examination are kept in a confidential file, and the results will not be used to withdraw the offer of employment unless the examination revealed that the applicant is not qualified.

Can an employer refuse to give an employee medical or other insurance coverage because it will raise the cost?

An employer must offer the same terms, conditions or privileges of employment to all employees, regardless of disability, and must not enter into contracts with any organization providing training, insurance or any other privilege of employment which discriminates against people with disabilities. Insurance, employee training, and other employee benefits must be equally available to employees with disabilities.

For example, if an insurance company will not insure an employee with Multiple Sclerosis, then the employer must find another insurer or otherwise comparable benefits. (Pre-existing claims, exemptions, or limitations on types of treatment - not types of illness - are acceptable if all employees are treated the same.) If the company has yearly parties for employees in an inaccessible location, the location must be changed.

What if the cost of insurance will increase not because of the employee, but his/her spouse or child?

spouse or child?

An employer cannot discriminate against a person with a disability because that person associates with a disability. An employer could not refuse to hire a person or offer different benefits because a spouse or a child with a disability might raise the employer's insurance rates.

What if an employer's customers or other employees feel uncomfortable around the employee with a disability?

Can the employer ask that employee to work at home, for example? An employer cannot segregate a person with a disability (for example, requiring a sales clerk with a disability to only work in the the stock room). Instead of segregating the employee, sensitize your employees to the rights of people with disabilities and the manner in which they should be treated.

What if an employer believes that the employee cannot perform the job safely, and he/she feels that the employee threatens the safety of employees and others?

An employer may require that an employee not pose a direct threat to the health or safety of other individuals in the workplace. This direct threat must be significant and immediate and must not be based on stereotypical assumptions but on real data. The employee must not be refused the opportunity of employment unless the direct threat cannot be eliminated with a reasonable accommodation.

An employer must research possible accommodations before rejecting an employee based on possible threats to safety. Calls to disability agencies (e.g., the Epilepsy Foundation) or the Centers for Disease Control may be helpful. The ADA has specific rules for food handlers with infectious diseases as listed by the Secretary of Health and Human Services.

TITLE II: STATE AND LOCAL GOVERNMENT

What are the requirements for state and local governments? Are they different from privately owned public accommodations?

Similar to Section 504 of the Rehabilitation Act of 1973, no state or local government entity may discriminate on the basis of disability in its programs or services. In addition to that general prohibition, state and local government entities must assure that all of its programs and services, when viewed in their entirety, are accessible. Thus every program must be accessible, but not every facility must be accessible.

Accessible features must be maintained in working order. All newly constructed or altered streets and walkways must have curb ramps regardless of the source of funding. The requirements apply not only to the state and local government entity, but also any private entity with which the government contracts to provide services. Thus, no government should contract with an entity which is totally inaccessible.

What constitutes discrimination by state and local governments?

Providing unequal, less effective, different or separate aids, services or benefits; providing services through an agency which discriminates; or denying the right to participate in planning or advisory boards are discriminatory. Using criteria or methods of administration, site selection for facilities, and licensing or certification which would have the effect of discrimination on the basis of disability violates the ADA. Services must be provided in the most integrated setting possible. Examples would include using written applications or only providing services in inaccessible locations.

If a government contracts with a private entity, are they subject to Title II?

Yes. If the government contracts with a private entity to provide services, then the delegate agency must

Yes. If the government contracts with a private entity to provide services, then the delegate agency must comply with Title II (and will also have Title II obligations).

Are there specific requirements for transportation?

Yes. Both Title II and Title III (public accommodations offered for transportation services offered by private entities) provide specific (and lengthy) requirements for transportation services offered by state and local governments and private operators.

In general:

- All new public buses and commuter trains must be accessible (lift-equipped, proper signage, warning symbols, etc.). For those people with disabilities who cannot use mainline transportation, paratransit (door-to-door) service must be offered with service response time, cost and availability comparable to the mainline service.
- At least one car per commuter train must be accessible; key stations must also be accessible.
- Over the road buses (Greyhound) will be "studied."
- All new Amtrak trains must be accessible; one car per train must be accessible; intercity rail stations must be accessible by 2010.
- New buses purchased by private entities not in the business of transportation (e.g., hotel shuttle services, buses offered to tour facilities such as the Chicago Botanic Garden) which seat more than 16 people (including the driver) must be accessible; if the service is "demand responsive" (available on demand) not all buses need to be accessible. If the buses purchased hold fewer than 16 people, the entity providing the service must assure that the service "when viewed in its entirety" is accessible to people with disabilities. The entity must be able to show that it can meet the demand for its services by people with disabilities within the same time frame as it meets the demand by non-disabled persons.

Are air carriers and airlines covered by the ADA?

Air transportation is not covered by the ADA, but is covered under the federal Air Carriers Act.

TITLE III: PUBLIC ACCOMMODATIONS

What is a public accommodation?

Public accommodations are any place, building, or outdoor space which a member of the public can enter with or without a fee. It does not include "private clubs" (those for which membership must be voted on by other members) and operations owned or operated by religious entities.

Categories of public accommodations listed in the ADA are:

- places of lodging (e.g., hotels, motels)
- establishments serving food and drink (e.g., restaurants, bars)
- places of exhibition or entertainment (e.g., theaters, stadiums)
- places of public gathering (e.g., auditoriums, convention halls)
- sale or rental establishments (e.g., bakeries, clothing stores, video stores)
- service establishments (e.g., professional offices of doctors, dentists, lawyers, gas stations, funeral parlors)
- stations used for public transportation
- places of public display or collection (e.g., museums, gardens, galleries)
- places of recreation (e.g., parks, zoos)
- places of education (e.g., private schools)
- social service centers (e.g., homeless shelters, day care centers)

- social service centers (e.g., homeless shelters, day care centers)
- places of exercise or recreation (e.g., gymnasiums, golf courses).

What in general must a public accommodation do or not do? A public accommodation:

- · cannot deny goods or services because a person has a disability or is associated with a person with a disability.
- · cannot offer only unequal or separate benefits, AND
- · must offer services in the most integrated setting possible.

Special programs for people with disabilities can still be offered, as long as the programs offered to all other people are still available to those with disabilities.

May a public accommodation require people with disabilities to meet certain standards of policies, especially safety standards?

A public accommodation must not use eligibility criteria or standards which screen out or tend to screen out people with disabilities unless it can be shown these criteria are necessary for the safe provision of these services. Safety considerations must be based in real, immediate threats of danger to others, not on stereotypical assumptions. In addition, a public accommodation must make reasonable modifications in policies, practices and procedures unless it would fundamentally alter the nature of the goods and services offered.

Although pets are not allowed, service animals must be allowed in gardens or other public accommodations. A "no-touching" policy may be necessary for delicate art work or fragile plants even though people with visual impairments may be denied the full enjoyment of these objects.

What special accommodations must public accommodations provide?

A public accommodation must provide, unless to do so would impose an undue administrative or financial burden, the following:

Auxiliary aids and services, including:

- sign language interpreters,
- assistive listening devices and headsets,
- brailled, large-print, and taped texts,
- TV decoders, and
- TDD/TTY (text telephone for the deaf, hearing and speech impaired).

Most of these items are relatively inexpensive and readily available. 15-point type, which is obtainable is most software programs or through an inexpensive update, is sufficient as large print for most users. TDD/TTYs, which are simple to use and do not require a separate phone line, start at \$250; \$500 TDD/TTYs have printers with which to record the conversation and built-in answering machines. Braille costs about 30 cents per page.

Auxiliary aids and services do not include devices or assistance of a personal nature, e.g., eyeglasses, hearing aid, or assistance with toileting.

What are the requirements for physical access for public accommodations?

A newly constructed public accommodation must meet all of the physical access requirements of the ADA Access Guidelines (ADAAG), unless a state standard is stricter.

For example, in Illinois, most of the state standards in the Illinois Accessibility Code (IAC) are stricter, so the IAC should be followed. The ADAAGs give an exemption to the general requirements of an elevator in new construction if the building is less than 3 stories tall or has less than 3,000 square feet per story (with certain exceptions to the exemption). The IAC has no such exemption and thus would have to be followed.

A public accommodation being remodeled must have the part being altered accessible to the "maximum extent feasible" according to the ADAAGs. If the part being altered is a primary function area (e.g., training center), then that area must be connected to the main entrance by an accessible route which includes accessible bathrooms, drinking fountains, etc. along the route.

It is possible that a public accommodation will have to follow parts of both the ADAAGs and a state's access code. An existing public facility which is not undergoing alterations must be made accessible if it is "readily achievable," meaning "without much difficulty or expense," according to the ADA. An entity should look at its total budget versus the cost of the features to determine whether the cost of accessibility would be undue. Examples of "readily achievable" alterations are: ramps, curb ramps, rearranging furniture, moving plants, widening doorways, putting tactile markers on elevators. Compare the cost of the alteration to the cost of decorative items.

If an existing facility cannot be made accessible, then it must provide service in an alternative manner, e.g., free delivery, taped tours of inaccessible exhibits, dixie cup dispensers on water fountains.

"Commercial facilities," meaning facilities not open to the general public but whose operations "affect commerce" (and everything does) must follow the rules for newly constructed or remodeled buildings.

Are there special criteria for professional examinations and courses?

The ADA specifically requires that any organization which offers examinations or courses related to secondary or postsecondary education, professional or trade purposes (e.g., SATs, law boards, CPA examinations, GREs) must offer them both in an accessible location and in an accessible manner.

TITLE IV: TELECOMMUNICATIONS FOR THE DEAF

What must be provided under this Title?

Any provider of local or long distance telephone service must provide a relay service for people who are deaf. Under this service, people with TDD/TTYs who are calling a party without a TDD/TTY, and vice versa, can make the call through a relay service, which will transmit the call via TDD/TTY or voice, depending on need.

What other requirements does Title IV have?

The only remaining requirement is that all public service announcements funded in whole or in part with federal funds must be close-captioned, meaning that a person with a special TV decoder will see the captioning.

TITLE V: MISCELLANEOUS PROVISIONS

What provisions are in this Title?

Several important provisions and some of lesser importance are included in this section. They include:

- The ADA shall not be construed to apply a lesser standard than that already in existence under Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794 et seq.) or to invalidate any state or local laws (such as the Illinois Accessibility Code) which have stricter provisions.
- The ADA will not prohibit an insurance company from using sound actuarial data to administer risks, even if the effect is that people with disabilities will be charged more or denied coverage, but it must not be used as a subterfuge to deny coverage.
- The ADA shall not be construed to require a person to accept an accommodation.
- There shall be no state immunity from action under the ADA, but Congress remains exempt, although it must abide by certain internal requirements.
- There is a prohibition against retaliation for filing a charge or opposing a discriminatory practice; retaliation will constitute a separate offense.
- Attorney's fees shall be awarded to the prevailing party.
- Various responsibilities for technical assistance and rule-making are outlined for the Architectural and Transportation Barriers Compliance Board, the Equal Employment Opportunity Commission, and the National Council on Disability.

Certain exclusions from the definition of "individual with a disability" are specified, inclusing homosexuals, current illegal drug users, and those with certain conditions (compulsive gambling, kleptomania, pyromania, sexual behavior disorders).

back to CDR's home page



The Florida Legislature Senate Select Committee on Medicaid Reform House Select Committee on Medicaid Modernization Public Hearing Comment Form

Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review.

Name:

Michael Aubin

Association: BayCave St. Joseph's Hospital/Assoc of FL Children's Ho
Address: 3001 W. D. M. L. King, Jr Blvd.
Address: 3001 W. D. M. L. King Jr Blvd. Tampa, FL 33607
(Please use the front and back of this sheet to provide your information.)
See attached statement and handouts.

Good Afternoon. My name is Michael Aubin and I am here representing BayCare Health System, St. Joseph's Hospital and the Association of Florida Children's Hospitals, which I presently serve as President. My initial remarks are related to BayCare and more specifically St. Joseph's Hospitals. My concluding remarks will be related to the Association of Florida Children's Hospitals.

BayCare is one of the largest non-profit healthcare systems in the country with over 16,000 employees dedicated to serving the greater Tampa Bay community. We serve as safety net providers to those in the greatest need of care and we do this without regard for an individual's ability to pay. BayCare's commitment to serve as a safety net provider is well illustrated by the services provide on our St. Joseph's Campus located in Tampa. On this campus we have three distinct hospitals:

- St. Joseph's Hospital, which serves the adult population in our region. 11% of the inpatients cared for in our hospital are covered by the Medicaid program;
- St. Joseph's Women's Hospital, which meets the region's women and obstetrics needs. Almost 29% of the inpatients served at Women's Hospital are covered by Medicaid; and
- St. Joseph's Children's Hospital of Tampa which meets broad regional needs for children's tertiary services. Almost 54 % of the children admitted at Children's Hospital are covered by Medicaid.

Overall, the Medicaid program covers almost 23% of the total inpatients served by our three hospitals on the Tampa campus.

The proposed funding cuts identified in the Governor's budget do not represent reform to the Medicaid program. These cuts represent unilateral attacks on already below cost reimbursement to our hospitals for taking care of the poorest and most vulnerable in our community. The real dollar estimated reductions in payments related to BayCare exceed \$36,000,000 in fiscal year 2005-2006. Of that amount cuts to St. Joseph's alone is estimated to be almost \$20,000,000.

We truly believe that Medicaid needs to be reformed and we stand ready to help lead this reform with concrete ideas and selected proven solutions.

We would love to see Medicaid patients who come to our high cost Emergency Center needing primary care to seek their care in dramatically lower cost locations such as urgent care centers.

We would love to have women get earlier prenatal care and have them carry their babies to full term and avoid our most costly Neonatal Intensive Care Unit.

We would love to see the special needs children in our region all participate in primary care medical homes to reduce their hospitalizations and emergency department visits.

All of these changes require reform and financial incentives to change the way the system has been designed to work in the past. We are prepared to help make these changes but they will not happen overnight. These changes will require years to craft by carefully testing pilot projects and then implementing refined systems across the state. We must remember that we are caring for real people, not just statistics on a budget printout.

Finally, I must address the children's hospitals in our state. The Association of Florida Children's Hospitals represents 12 children's hospitals located geographically across the state. These 12 children's hospitals take care of more than 55% of all of the children's Medicaid patient days in the entire state of Florida. This compares with the 45% of children's Medicaid days provided at the remaining 192 other hospitals in the state. This startling statistic underlines the key Safety Net role for Medicaid children's services that our children's hospitals provide. We are the providers of care to the sickest of the sick. We also are the most vulnerable to changes in the Medicaid program. The reductions in payments proposed in the Governor's budget and in suggested changes to the program will have devastating consequences on children's hospitals viability.

A preliminary analysis of the proposed cuts in Medicaid will entirely wipe out the small bottom line that St. Joseph's Children's Hospital has had in the past to fund needed program expansions and necessary capital improvements. These cuts will create a cycle of program and service reductions in order for us attempt to remain viable.

We do not believe this is the track that our Legislature wants us to follow. We urge you and your colleagues to bring us to the table to reform the system in a rational and logical manner. We believe there are cost savings to be achieved while actually improving the services we provide to the neediest citizens of our state.

Thank you.



Saving Children's Lives

St. Joseph's Children's Hospital of Tampa is committed to providing everything needed for the health and well-being of children. As Tampa's first dedicated children's hospital, our 174-bed facility meets the unique needs of children and their families. We provide high-tech pediatric health care in a child-friendly environment. Our specialized pediatric services are further strengthened by St. Joseph's full-service medical center.

Pediatric Intensive Care and Cardiac Intensive Care Units

St. Joseph's Children's Hospital has a 16-bed Level I Pediatric Intensive Care Unit and the 7-bed Gary S. Haas, M.D., Cardiac Intensive Care Unit. In these specialized environments, critically ill children receive the most advanced care possible from certified nursing, allied health, and medical staff teams. Family accommodations are offered in each unit.

Children's Heart Center

The Children's Heart Center offers cardiac intensive care, intermediate care, a cardiac catheterization lab, an operating suite, a non-invasive cardiology center and a remote cardiac imaging center. It is one of the most comprehensive, up-to-date children's cardiac centers in the nation.

Many children with congenital heart disease grow up to be adults with heart issues. That's why we also offer the Adult Congenital Heart Disease (ACHD) Program.

Neonatal Intensive Care Unit

In our 48-bed Level II and Level III Neonatal Intensive Care Unit, family-centered care is provided to critically ill infants. Our team includes certified nurses and 24-hour, in-house board-certified neonatologists.

Medical/Surgical Units

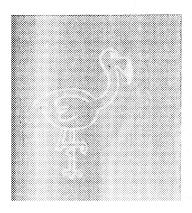
We offer 93 private family suites designed to meet children's complex medical and surgical needs. The suites offer televisions, computers, Internet access and video games. Sleeping, showering and laundry services are available for parents. There is also a special 10-bed day hospital for children who need observation or require minor procedures.

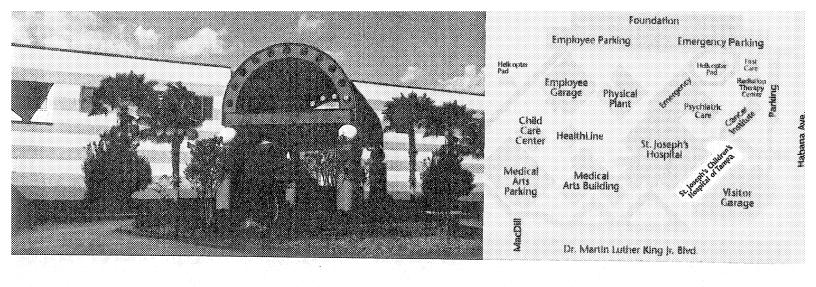
Steinbrenner Emergency Center for Children

The 18-bed Steinbrenner Emergency Center for Children is a state-designated pediatric trauma center. It serves the emergency and trauma care needs of Tampa Bay area children 24 hours a day, seven days a week.

Children's Diabetes and Nutrition Center

Our certified diabetes educators and registered dietitians provide group and individual classes for children with Type 1 and Type 2 diabetes. Dietitians also provide care for children with metabolic and nutritional disorders.





Pediatric Specialty **Medical Staff**

St. Joseph's Children's Hospital of Tampa is strengthened by its medical staff of over 80 pediatricians and more than 140 specialists in the following areas:

- Allergy and Immunology
- Anesthesiology
- Cardiology
- Cardiothoracic Surgery
- Critical Care
- Developmental **Pediatrics**
- Emergency Medicine
- Endocrinology and Metabolics
- Gastroenterology
- General Surgery
- Genetics
- Hematology/Oncology
 Radiation Oncology
- Infectious Disease
- Neonatology
- Nephrology

- Neurology/ Epileptology
- Neurosurgery
- Ophthalmology
- Orthopedics
- Otolaryngology (ear, nose and throat)
- Otology
- Pathology
- Plastic/Maxillofacial Surgery
- Psychiatry
- Pulmonology
- Radiology
- Rehabilitation
- Rheumatology
- Urology

Child Life Program

Our child life specialists help hospitalized children and their families adjust to our environment with:

- Patient orientation to hospital and procedures
- Preoperative preparation
- Accompanying patients through unfamiliar medical procedures
- Pain management/coping skills
- Sibling and peer support groups

Children's Outpatient **Specialty Centers**

St. Joseph's Children's Hospital of Tampa offers outpatient services at our Physician Specialty Centers both on and off campus. At these centers. our medical staff works closely with family members and their primary care physicians to provide children with family-centered outpatient care. Our off-campus centers are located in:

Hillsborough County	Manatee County
Brandon	Bradenton
New Tampa	Pasco County
Polk County	Trinity
Lakeland	Pinellas County
	Carillon

Children's Hematology/ **Oncology Center**

Children receive diagnosis, treatment and family support through a team approach, with numerous health care professionals lending their expertise:

- Pediatric hematology/oncology physician specialists
- Pediatric nurses and nurse practitioners
- Certified child life specialists
- Pediatric social workers
- Chaplains
- Pediatric radiation oncologists
- Pediatric research nurses



Children's Rehabilitation

Rehabilitation therapy for children is provided for inpatients and outpatients at our five state-of-the-art rehab centers:

- Rehab 1-2-3 is the only center of its kind in the southeastern United States
- The Motion Analysis Center provides treatment for children with walking problems
- Satellite Centers focus on occupational, physical and speech therapy, as well as audiology (Brandon only). Centers are located in:

Hillsborough County Pasco County Brandon Trinity New Tampa Pinellas County **Polk County** Carillon Lakeland

Home Health Care

Our Home Health Care program helps ensure a smooth transition from the hospital to home. Our team will work with your child's physician and your family to coordinate comprehensive services.

Children's Advocacy Center

Our Children's Advocacy Center is committed to promoting the health and welfare of children through education and governmental advocacy efforts.

Special programs, groups and classes for families provide support and up-to-date health care information.

3001 W. Dr. Martin Luther King Jr. Boulevard, Tampa, FL 33607 For more information call (813) 554-8500

Talking Points for Chronic Complex Clinic St. Joseph's Children's Hospital of Tampa Medicaid Reform Public Forum Feb. 11, 2005

St. Joseph's Children's Hospital of Tampa, in cooperation with Florida Pediatric Associates, provides a comprehensive primary care practice to address the special health care needs of children with complex medical conditions. Our clinic provides a medical home for these children and their families, coordinating their specialty care, addressing psychosocial concerns and providing continuity of care during their hospitalizations.

Approximately 85% of the 340 patients seen in the clinic are covered by Medicaid. Medicaid is the key health care safety net program for Florida's families, and typically children, while representing a large percentage of those covered, represent a proportionally small percentage of the actual costs. The exception in that category are the chronic and medically complex children. For the last two years we have studied the cost effectiveness of providing coordinated, family-centered care for this population and found it not only resulted is savings, but also in better health outcomes and higher family satisfaction.

In considering creative approaches to Medicaid reform, we would like an opportunity to present our findings and propose a pilot program. Our study documented that providing a true medical home for families with children with chronic complex conditions resulted in:

- A significant decrease in the number of hospitalizations
- Shorter lengths of stay when patients were hospitalized.
- Fewer emergency room visits.
- Savings averaged over \$3600 per patient.
- Parents reported being extremely satisfied with the care that was provided to their children and felt that the services provided by the Center improved their family functioning.

The results of the study clearly indicate the tangible and intangible benefits to providing care through this medical model. We would like the opportunity to further present our findings and explore the potential of establishing a pilot program that would provide high quality health care for these families that will ultimately result in cost savings for the state.

Thank you for this opportunity.

Abstracts of Quality and Cost-effectiveness Studies¹ St. Joseph's Children's Hospital Complex Chronic Pediatric Center

Background

Over the past quarter century there has been a plethora of publications identifying the complex service needs of children with special health care needs and their families (CSHCN). However, the vast majority of those articles found that there are few programs of service coordination that are comprehensive in scope. To date, no published articles objectively evaluate an existing hospital-based care coordination program such as the St. Joseph's Children's Hospital Complex Chronic Pediatric Center. Consequently, the studies summarized in this abstract have implications for future potentially publishable, peer-reviewed research.

Purposes of Study

The purposes of these studies were to determine the strengths and weaknesses (SW) and the cost-effectiveness (CE) of the Complex Chronic Pediatric Center at St. Joseph's Children's Hospital (Center). The SW study attempted to determine which attributes of the Center were significant to families' perception of quality; how those attributes were qualitatively rated; and which of the attributes contributed to family functioning. The CE study attempted to determine whether there were significant differences in hospital service utilization among children who are not enrolled in the Center and those who are enrolled at the Center.

Findings

The SW study of 79 fully completed surveys found that overall quality correlated with the quality of interactions between the family and professionals and other staff of the Center. The number one attribute that is correlated with overall quality was the "extent to which nurses answer all of your questions completely." The next five in descending order include: "doctor/nurse practitioner makes an extra effort to meet your needs and the needs of your child"; "medical advice available when you need it"; "doctor/nurse practitioner provides you an opportunity to participate in the decisions about your child's care"; "doctor/nurse practitioner listens to what you have to say," and "secretary calls to remind you of your upcoming appointment." Family functioning appeared most highly correlated with the helpfulness of the Center, specifically the item, "Sensitivity/understanding of doctor/nurse practitioner to your background and beliefs about how to take care of your child".

The CE study found that the number of emergency-room visits, number of hospitalizations and length of stay were found to be significantly lower for 49

¹ The studies were conducted by Rebecca Olsen Ph.D., Healthcare Quality Consultant. This abstract was prepared by Steve A. Freedman, Ph.D., Professor-emeritus of Pediatrics and Political Science, University of Florida.

participants in the Center for whom data was available. Indeed, the cost savings from reduced utilization (hospital days and emergency department visits) was estimated at over \$225,000 for that group.

Limitations

The findings of both of the studies may not be generalized to other sites or groups because of the small sample sizes. However, the SW study provided accurate data for the Center regarding how well they perform on attributes of child healthcare quality and potential improvement strategies. The CE study lacked comprehensive pre-enrollment hospital utilization data, resulting in assumptions about utilization for that analysis; and there was some missing diagnostic information for emergency department and hospital visits. That missing information limited the researcher's ability to eliminate visits that could have been prevented by the Center.

Conclusions and Recommendations

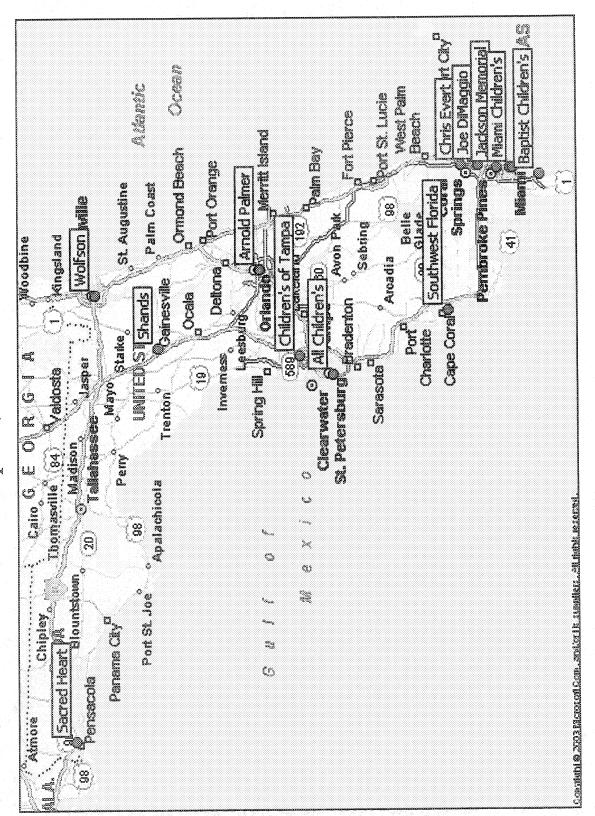
The SW study found that the Center provided excellent healthcare quality from the parent perspective. In that study, the parents reported being extremely satisfied with the care that was provided to their children; and from their perspective the services at the Center improved their family functioning. The parents expressed a dependency on the Center because of the comprehensiveness and quality of the services provided.

The CE study strongly indicates that there was an association between a decrease in emergency department visits, hospital admissions, and length of stay with enrollment in the Center; hence, creating a cost savings to the St. Joseph's Children's Hospital.

The results of both studies clearly indicate the tangible and intangible benefits of the Center, from a quality, parent, organizational and financial perspective. While the studies abstracted here are indicative of positive outcomes, there is more work to be done to confirm their findings. Should the findings of these studies become generalizable, the Center's model of exceptional care might be adopted by other hospitals offering services to comparable populations.

These studies can provide solid foundations for future research. It is recommended to continue the surveys until there is enough data to perform inferential statistical analyses. This will enable the researcher to determine which attributes of care are more significant to parents; this, in turn, will enable the Center to develop the improvement strategies that are most important to the population they serve. In addition, it is recommended that the information infrastructure be improved to require the electronic capture of data relevant to cost-effectiveness comparisons.







Association of Florida Children's Hospitals, Inc.

& Percent of Florida Medicaid Pediatric Patient Days 2003 Pediatric Medicaid Patient Day Volume*

AFCH Total Patient Days - 280,024 Total Patient Days - 507,219

Hospitals All Other 44.8% AFCH Members 55.2%

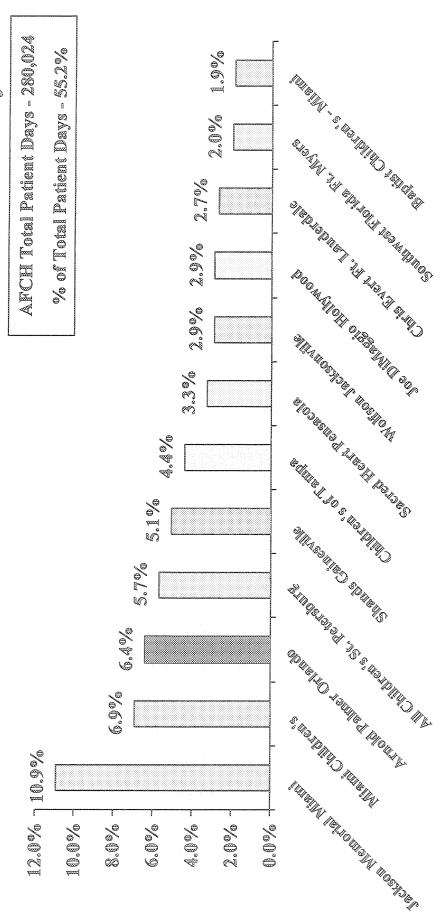
*All medical/surgical pediatric (0-17) and neonatal patients excluding normal newborns, psychiatric and obstetric patients.

Source: MedStat/AHCA Database

A seption of the state of the s

Association of Florida Children's Hospitals, Inc.

& Percent of Florida Medicaid Pediatric Patient Days 2003 Pediatric Medicaid Patient Day Volume*



Source: MedStat/AHCA Database stAll medical/surgical pediatric (0-17) and neonatal patients excluding normal newborns, psychiatric and obstetric patients.



Association of Florida Children's Hospitals, Inc.

A Council of the Florida Hospital Association

Member Hospitals provide the care for over 53% of all pediatric patient days and 55% of all pediatric Medicaid patient days. The vast majority of chronically ill children in the state of Florida are cared for by these children's hospitals.

- All Children's Hospital, St. Petersburg
- Arnold Palmer Hospital for Children and Women, Orlando
- Baptist Children's Hospital, Miami
- o Children's Hospital at Sacred Heart, Pensacola
- The Children's Hospital of Southwest Florida,
 Ft. Myers
- Chris Evert Children's Hospital at Broward General Medical Center, Ft. Lauderdale
- Holtz Children's Hospital at UM/Jackson Memorial Medical Center, Miami
- Joe Di Maggio Children's Hospital, Hollywood
- Miami Children's Hospital, Miami
- Shands Children's Hospital at the University of Florida, Gainesville
- St. Joseph's Children's Hospital of Tampa, Tampa
- Wolfson Children's Hospital, Jacksonville

In 1999, the Association of Florida Children's Hospitals was organized to enhance and improve children's healthcare in Florida. This collaborative effort of children's hospitals seeks to accomplish this mission by focusing on the following areas:

- Patient Care by sharing knowledge of efficiencies, methods, new technologies and legislative needs
- Education by promotion of educational efforts for physicians, allied healthcare professionals, families and patients
- Research by promoting and sharing efforts in state, national, and international participation in clinical and basic programs
- Child Advocacy by providing a voice for our young citizens to ensure their health and well being throughout the state of Florida

Through the sharing and dissemination of knowledge, information, experiences, and research, the AFCH encourages the development of the most effective means of delivering comprehensive healthcare to the children of Florida.